HARBOR SQUARE DENTAL

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DENTAL HISTORY

Patient Name_____ Date of Birth _____
Previous Dentist (name & location)_____
Date of last visit_____ Date of last dental X-rays _____
What was done at your last dental visit?_____
How often were you getting your teeth cleaned?_____
Are you in pain today? **YES** **NO** Location_____

FOR DENTAL PATIENTS OVER THE AGE OF 7

DENTAL SYMPTOMS: please check if you have any of the following:

◊ Chew on one side of mouth
◊ Cracked or broken teeth/fillings
◊ Sensitivity when biting
◊ Sensitivity to hot
◊ Sensitivity to cold
◊ Sensitivity to sweets
◊ Sensitivity when brushing
◊ Unhappy with the appearance of your teeth

PERIODONTAL SYMPTOMS: please check if you have any of the following:

◊ Bleeding gums with brushing and/or flossing
◊ Swollen or tender gums
◊ Loose teeth
◊ Tartar build-up (calculus deposits)
◊ Bad breath
◊ Food collection between teeth
◊ Diagnosis of gum disease (periodontal disease)
◊ Deep cleanings at a previous dental office

How often do you brush? _____
How often do you floss? _____
How would you rate your current dental health?
Poor **Fair** **Good** **Excellent**
What type of tooth brush do you currently use?
Manual **Electric**
What type of bristles? **Soft** **Med** **Hard**

HABITS: please check if you do any of the following:

◊ Smoke cigarettes, pipes or cigars
◊ Use smokeless tobacco
◊ Bite fingernails
◊ Chew ice
◊ Drink more than 12 ounces of soda, juice, sports drinks, or flavored coffee each day

TMJ (Temporomandibular Joint): please check if you have any of the following:

◊ Clicking or popping jaw
◊ Grinding teeth at night
◊ Clenching teeth
◊ Pain or tiredness in jaw or jaw muscles
◊ Pain around ear
◊ Headache or pain in jaw on awakening
◊ Unable to open wide
◊ Unable to close jaw
◊ Night Guard (and wear it nightly!)
◊ Treatment for TMJ disorder
◊ TMJ surgery

OTHER: Please write down any other dental history we should be aware of, including surgeries or negative dental experiences
_____
_____
_____
_____
_____

PATIENTS UNDER 7 YEARS OF AGE

Has your child been to the dentist before?	YES	NO
Has your child had dental x-rays?	YES	NO
How often does your child brush and floss their teeth? _____		
Does your child receive help brushing and flossing?	YES	NO
Does your child have a source of fluoride other than toothpaste?	YES	NO
Please describe: _____		
Does your child get a bottle or nurse at night?	YES	NO
Does your child have any habits such as thumb sucking or pacifier?	YES	NO
Please describe: _____ _		
Have you or your spouse had any serious dental problems?	YES	NO

Please describe anything else about your child you feel we should know:
_____
_____Dr. Initials____Date_____