Time 10:03 AM

Fifth Street Dental Care

Dental History

Date 9/23/2015

Patient Name:

Birth Date:

Date Created:

Daily Habits

How many times a day do you brush your teeth?

How many times a week do you floss?

What kind of tooth brush do you use?

Do you use a mouth wash? ◯ Yes ◯ No If yes

Do you use a water pick? ◯ Yes ◯ No If yes

Your Teeth

Do you have any dental pain? ◯ Yes ◯ No If yes

When was your last dental cleaning and exam?

Have you had braces? ◯ Yes ◯ No If yes

Have you had your 3rd molars (wisdom teeth) removed? ◯ Yes ◯ No If yes

Do you drink pop/energy drinks? ◯ Yes ◯ No If yes

Have you ever been diagnosed with periodontal disease? ◯ Yes ◯ No If yes

Have you ever had scaling and rootplaning (deep cleaning)? ◯ Yes ◯ No If yes

Anything you would like to change about your smile? ◯ Yes ◯ No If yes

TMJ

Do you clench or grind your teeth?

- ☐ grind
- ☐ clench
- ☐ during the night
- ☐ during the day

Do you have pain or popping in the jaw joint?

- ☐ popping but no pain
- ☐ popping with pain
- ☐ my jaw has locked open
- ☐ my jaw has locked closed
- ☐ headache in the morning
- ☐ hurts to chew gum

Do you have a bitesplint? ◯ Yes ◯ No If yes

Anything we can do to make your visit more comfortable?

Signature of Patient, Parent or Guardian:

X

Date:_____