Patient Dental History

Dietrich Family Dentistry Inc.

When was your last dental visit? _____

When did you last have dental x-rays taken? _____

How often do you brush your teeth? _____

How often do you floss? _____

	Yes	Don't Know or N/A:	No
Have you been seeing a dentist regularly?	☐	☐	☐
Do any of your teeth ache?	☐	☐	☐
Have you ever been advised to take antibiotics before dental appointments?	☐	☐	☐
Do your gums bleed when you brush?	☐	☐	☐
Do you have any pain when you chew?	☐	☐	☐
Do you feel that you have bad breath?	☐	☐	☐
Have you ever been in a vehicle accident or experienced any trauma to your jaw?	☐	☐	☐
Have you ever had any implant surgery ?	☐	☐	☐

If you answered yes to the last question, who performed the surgery and when was it done?

_____ Date _____

Are you being followed-up by a dental specialist? _____

Do you have any problems with your jaw joint (pain, sounds, limited opening, locking, popping)?	☐	☐	☐

Is there anything about the appearance of your teeth you would like to change? _____

Please list anything not mentioned above regarding your past dental history:

_____

_____