

Milford Dental Clinic

DENTAL HISTORY

Please describe your chief oral complaint:

Are your teeth sensitive to:	Yes	No
Heat?	___	___
Cold?	___	___
Sweets?	___	___
Chewing?	___	___

Do you have any food traps? ___ ___

Do your gums ever feel tender or swollen? ___ ___

Do your gums bleed when brushing? ___ ___

Do you have any teeth that feel loose? ___ ___

Have you been treated for periodontal disease? ___ ___

Do you use dental floss? ___ ___

Have you had any injuries to your face or jaw? ___ ___

Have you ever had your teeth straightened/braces? ___ ___

Do you clench or grind your teeth? ___ ___

Do you strike some teeth before others when closing? ___ ___

Have you ever had your bite adjusted? ___ ___

Do your jaws ever feel tired or ache? ___ ___

Can you chew comfortably? ___ ___

Have you had a complete dental exam including full mouth x-rays in the past 3 years? ___ ___

Do you have your teeth cleaned regularly? ___ ___

When was your last cleaning? ___ ___

Do you have all your natural teeth? ___ ___

Would you like to keep your natural teeth? ___ ___

Are missing teeth replaced? ___ ___

Do you like the appearance of your smile? ___ ___

Do you consider yourself a nervous patient? ___ ___

Have you ever had a bad dental experience? ___ ___

Have you had issues with local anesthetics? ___ ___

Physician's Name _____ Phone # _____

Last visit to physician _____ Last Complete Physical _____

If you could change your teeth/smile, how would you? _____

When was your last dental visit? _____

What was done at that visit? _____

Where was it done? _____