Divine Dental Center

Dental Health Form

Patient's Name: _____

Previous Dentist: _____ How long were you a patient? _____Months/Years

Reason for leaving: _____

Date of most recent dental exam ___/_____/_____ Date of most recent x-rays _____/_____/_____

Date of most recent treatment (other than a cleaning)____/_____/_____Type of treatment: _____

1. Are you having any discomfort at this time? Explain: _____
2. Have you ever had any serious complications associated with previous dental procedures? Explain: ____
   _____
3. Does dental treatment make you nervous? No ____ Slightly _____ Moderately ____Extremely _____
4. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? _____
   If so, when: _____
5. How often do you brush? _____ Toothbrush is: soft _____ Medium _____ Hard _____
6. How often do you floss your teeth? _____
7. Do you have, or have you ever had any of the following? Please check those that apply:

MOUTH

- □ Bleeding, sore gums
- □ Unpleasant taste/bad breathe
- □ Burning tongue/lips
- □ Frequent blisters, lips or mouth
- □ Swelling/lumps in mouth
- □ Braces
- □ Biting of cheeks/lips
- □ Clicking/popping jaw
- □ Difficulty opening or closing jaw

TEETH

- □ Loose teeth
- □ Sensitivity to heat
- □ Sensitivity to cold
- □ Sensitivity to sweets
- □ Sensitivity to biting
- □ Food impaction
- □ Clenching/grinding
  If so, when? _____
- □ Shifting in bite
- □ Change in bite

8. Are you happy with your smile and the appearance of your teeth in general (Color, Shape, Spaces)? ___
   If no, why not? _____
   _____
9. How would you rate the condition of your mouth? □ Excellent □ Good □ Fair □ Poor

Patient/Responsible party's Signature: _____ Date_____

Doctor's Signature: _____ Date_____