CLEAR CREEK DENTISTRY

Patient Dental History

Name _____ Date _____

1. What is your present dental concern? _____ Services Desired _____

2. Please describe your general dental health? _____

3. How long since your last dental visit? _____ Former Dentist _____

4. How long since your last dental cleaning visit? _____

5. Do you think you have active decay or gum disease? Y N

6. Are you worried about receiving dental treatment? Y N

7. Have you ever had an unusual reaction or problem with dental anesthetic or treatment? Y N

8. How often do you brush? _____ Brush Type: Soft Medium Hard

9. Do you use fluoride toothpaste? Y N

10. How often do you floss? _____ What other oral homecare products do you use? _____

_____

11. Is there anything you would change about the appearance of your teeth? Y N

12. Are you missing any teeth? Y N

13. Have they been replaced by bridges, partials, dentures or implants? Y N

14. Do your gums bleed when brushing or flossing? Y N

15. Does food pack between any teeth? Y N

16. Are any teeth sensitive to hot, cold, sweets, or pressure? Y N

17. Do you have a regular high sugar consumption habit (pop, hard candy, mints etc.)? Y N

18. Do you chew gum or hard objects such as ice, popcorn kernels, etc? Y N

19. Do you ever have popping, clicking, or discomfort in your jaw joint (TMJ)? Y N

20. Are you aware of clenching or grinding your teeth during the day or night? Y N

21. Do you have frequent headaches? Y N

22. Do you or have you ever worn a night guard? Y N

23. Do you have or have you had any slow healing sores or growths in your mouth? Y N

24. Circle any of the following concerns you have about your mouth, teeth and gums:

Bad Breath	Spaces	Periodontitis	Discolored Fillings
Bad Taste	Infection	Loose Teeth	Smile
Broken Teeth	Swollen Gums	Shifting Teeth	Gag easily
Missing Teeth	Red Gums	Appearance	Crooked Teeth
Old Fillings	Bleeding Gums	Bad Bite	Other:
Broken Fillings	Gingivitis	Dark Teeth	_____

25. How important is it to you to keep your existing natural teeth the rest of your life? _____

CHILDREN TO AGE 14 YEARS –

26. Is your current drinking water fluoridated? Y N

27. Is your child taking supplemental fluoride tablets/drops? Y N

28. Have your child's permanent molars been sealed? Y N

29. Does your child have any oral habits such as thumb sucking, lip biting, or mouth breathing etc.? Y N