DENTAL HISTORY

PATIENT NAME: TODAY'S DATE: / /

What is your main reason for visiting the dentist today?:

Who was your previous dentist?:

When was your last dental visit?

How often do you visit the dentist?

How often do you brush your teeth?

How often do you floss your teeth?

	Yes	No
Have you lost any teeth or had any teeth extracted?	☐	☐
If yes, what was the reason?		
Have you had any teeth replaced with:		
Dental Implants?	☐	☐
A Dental Bridge?	☐	☐
A Partial Denture?	☐	☐
A Complete Denture?	☐	☐
Do you have any teeth that are sensitive to:		
Hot?	☐	☐
Cold?	☐	☐
Sweets?	☐	☐
Biting Pressure?	☐	☐
Do your gums bleed when you brush or floss?	☐	☐
Does food wedge between any of your teeth?	☐	☐
Do you ever clench or grind your teeth?	☐	☐
Do you have pain in or around either of your jaw joints?	☐	☐
Do you wear a night guard?	☐	☐
Have you ever had an injury to your head, face or neck?	☐	☐
Do you feel that you have occasional or frequent bad breath?	☐	☐
Do you have an unpleasant taste in your mouth?	☐	☐
Have you noticed any swelling, lump, or growth in or around your mouth?	☐	☐
Have you noticed any discolored areas on your head, face or neck?	☐	☐
Have you ever worn braces, invisalign, or a retainer?	☐	☐
Have you ever had gum treatments or gum surgery?	☐	☐

	Yes	No	Maybe
Are you interested in whitening your teeth?	☐	☐	☐
Are you interested in a Cosmetic Dental Consultation with Dr. Lutes?	☐	☐	☐