DENTISTRY AT

WINDERMERE

Dental History

Welcome! We are so glad that you are here. Please complete this dental history form so that we may provide you with the best possible care. All information is kept confidential.

Date:________________________ Name:____

Reason for your visit today?____

____

____

Approximate Date of:

Last Dental Exam: __________________ Last Cleaning:__________________ Full Set of X-rays: ________________

Dental Anxiety Level: ☐Low ☐Normal ☐High

What kind tooth brush do you use? ☐Manual ☐Electric What type? ☐Soft ☐Medium

Do you use any other dental aids? (check all that apply) ☐Waterpik ☐Toothpicks ☐Fluoride rinse

☐Mouth Wash ☐Other____

How often do you brush?____________________________ How often do you floss?_______________________________

Are any of your teeth sensitive to: (check all that apply) ☐Hot ☐ Cold ☐Sweets ☐Chewing /Pressure

Have you ever had *(check all that apply):*

☐ Orthodontic treatment/Braces
☐ Endodontic treatment/Root Canal
☐ Extractions/Oral Surgery
☐ Gum Surgery
☐ Biting Lips or Cheeks
☐ Scaling and root planning/Deep Cleaning

☐ Cold Sore/Fever Blister
☐ Frequent Canker Sores
☐ Smoking
☐ Chewing Tobacco
☐ Occlusal or Bite adjustment
☐ Teeth Whitening/Bleaching

☐ Clicking or Popping of the Jaw
☐ Pain in Ear, Jaw or Face
☐ Difficulty Opening or closing mouth
☐ Frequent Headaches
☐ Excessive Stress

Check any that apply to you:

☐ Bleeding or Painful Gums
☐ Bad taste in your mouth
☐ Loose Teeth

☐ Wearing Night guard
☐ Food catching between your Teeth
☐ Clench/grind teeth

Signature: ____ Date:______________________________

(Patient/Parent or Guardian)