Dental History

Patient Name:_____ Birth Date: _____

Upstate Family Dental considers your dental history an important tool in treating you today and in future visits. Thank you for taking the time in answering the following questions so we can help you achieve optimum oral health for a lifetime.

1. Purpose for today's Visit: _____
2. How long has it been since your last dental cleaning/exam? _____

Circle the appropriate answer. If you do not know the correct answer please write "don't know" on the line after the question.

3. If you have replacement teeth from extractions, (examples: bridges, dentures, implants, partials) are you happy with the fit? YES NO
4. Would you like to learn about permanent tooth placement? YES NO
5. Do you clench or grind your teeth? YES NO
6. Are your teeth sensitive to: Cold Hot Sweets Biting Pressure
7. Does food get caught in between your teeth? YES NO
8. Do your gums bleed or hurt? YES NO
9. Do you experience dry mouth? YES NO
10. How often do you brush your teeth? _____
11. How often do you use dental floss? _____
12. Are any of your teeth loose, shifted, or chipped? YES NO
13. Are you happy with your smile and the color of your teeth? YES NO
14. Do you feel your breath is offensive at times? YES NO
15. Do you have a family history of gum or teeth problems? YES NO
16. Do you or have you previously: Smoked Dip Tobacco Drink Alcohol Used Other Drugs
17. Have you ever had a "deep cleaning" or gum surgery? YES NO
18. Are you anxious about going to the dentist? YES NO
19. Is there anything you would like to share with us that would help us ensure your visit with us is a pleasant experience? _____

_____

20. What time would work best to accommodate your needs?

Morning:_____ Mid Morning:_____ Afternoon: _____

21. Referral source to our office: _____

I certify that the above information is complete and accurate.

Patient/Guardian's Signature:_____Date: _____