PATIENT DENTAL HISTORY

Brittain Dental

First Name:

Last Name: **Date of Birth:**

When was your last dental visit?

When did you last have dental x-rays taken?

How often do you brush your teeth?

How often do you floss?

	Yes	Don't Know or N/A	No
Have you been seeing a dentist regularly?	○	○	○
Do any of your teeth ache?	○	○	○
Have you ever been advised to take antibiotics before dental appointments?	○	○	○
Do your gums bleed when you brush?	○	○	○
Do you have any pain when you chew?	○	○	○
Do you feel that you have bad breath?	○	○	○
Have you ever been in a vehicle accident or experienced any trauma to your jaw?	○	○	○
Have you ever had any implant surgery ?	○	○	○

If you answered yes to the last question, who performed the surgery and when was it done?

Date

Are you being followed-up by a dental specialist?

Do you have any problems with your jaw joint (pain, sounds, limited opening, locking, popping)? ○ ○ ○

Is there anything about the appearance of your teeth you would like to change?

Please list anything not mentioned above regarding your past dental history:

Patient Signature: **Date:**