HERITAGE DENTAL

Name: _____
First Middle Initial Last

Dental History

When did you last visit a dentist? _____
Were x-rays taken? ☐Yes ☐No If yes, when taken? _____

When did you last have your teeth cleaned? _____

Have you ever had periodontal scaling/root planing (deep cleaning under the gum tissue)?

☐Yes ☐No If yes, when? _____

Did you have a full mouth x-ray taken within the last 5 years that can be transferred?

☐Yes ☐No If yes, when taken? _____

If yes, name of dentist/clinic _____
Address _____
City/State/Zip _____
Phone No. _____
Fax No. _____
Approx. when taken? _____

Do you have any discomfort at this time? ☐Yes ☐No
If yes, explain _____

_____

Please check (x) any of the following that apply to you now or in the past

- ☐ Pain in or near ears
- ☐ Jaw joint noise (clicking)
- ☐ Locked Jaw
- ☐ Bite is off
- ☐ Braces
- ☐ Any difficult extraction
- ☐ Other _____

- ☐ Food collects
- ☐ Teeth sensitive to pressure
- ☐ Teeth sensitive to sweets
- ☐ Teeth sensitive to cold
- ☐ Teeth sensitive to hot
- ☐ Prolonged bleeding following Extraction(s)

- ☐ Clenching or grinding
- ☐ Unpleasant taste
- ☐ Periodontal/gum disease
- ☐ Mouth sores
- ☐ Gums bleeding
- ☐ Smoker/tobacco user

_____

_____ Date _____
Signature of patient, parent, or guardian