Twain Harte
Family Dental Care
A Professional Dental Corporation

DENTAL HISTORY

DATE:________________________

FULL NAME:____

PREVIOUS DENTIST: ____ CITY: ____

LAST DENTAL VISIT: ________________________________ LAST DENTAL XRAYS: ____

WHY HAVE YOU COME TO THE DENTIST TODAY: ____

DOES DENTAL TREATMENT MAKE YOU NERVOUS? ☐ NO ☐ SLIGHT ☐ MODERATE ☐ SEVERE

ARE YOU CURRENTLY IN PAIN? ☐ YES ☐ NO IF YES, WHERE? ____

YOUR CURRENT DENTAL HEALTH IS: ☐ GOOD ☐ FAIR ☐ POOR

DO YOU LIKE YOUR SMILE? ☐ IT'S OK ☐ YES ☐ NO DO YOUR GUMS BLEED? ☐ YES ☐ NO

ARE YOU INTERESTED IN TOOTH WHITENING? ☐ YES ☐ NO

HOW MANY TIMES A DAY DO YOU BRUSH? _________/DAY HOW MANY TIMES A WEEK DO YOU FLOSS? _________/WEEK

HOW OFTEN DO YOU USE A FLOURIDE RINSE? _________/WEEK

HAVE YOU EVER HAD OR DO YOU HAVE ANY OF THE FOLLOWING?

☐ YES ☐ NO FEVER BLISTERS/COLD SORES

☐ YES ☐ NO CANKER SORES

☐ YES ☐ NO ORTHO TREATMENT (BRACES) -WHAT AGE________

☐ YES ☐ NO CLENCHING/GRINDING OF TEETH

☐ YES ☐ NO THUMB/FINGER SUCKING

☐ YES ☐ NO PROBLEMS SLEEPING

☐ YES ☐ NO SNORING

☐ YES ☐ NO SORE THROAT

☐ YES ☐ NO BURNING TONGUE OR LIPS

☐ YES ☐ NO SWELLING/LUMPS IN MOUTH

☐ YES ☐ NO CLICKING/POPPING OF JAW

☐ YES ☐ NO PAIN/DISCOMFORT IN JAW

☐ YES ☐ NO MOUTH BREATHING

☐ YES ☐ NO ALLERGIES

☐ YES ☐ NO TOUNGE THRUST

☐ YES ☐ NO SPEECH

HAVE YOU EVER BEEN TREATED FOR PERIODONTAL DISEASE (GUM DISEASE, PYRORRHEA, TRENCH MOUTH)? ☐ YES ☐ NO

IF YES, WHEN? ____

DO YOU HAVE ANY OTHER DENTAL CONDITION THAT WE SHOULD KNOW ABOUT? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN: ____

____

HAVE YOU HAD ANY UNUSUAL DIFFICULTIES WITH THE USE OF DENTAL ANESTHETIC? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN: ____

I UNDERSTAND THAT THE INFORMATION THAT I HAVE GIVEN TODAY IS CORRECT TO THE BEST OF MY KNOWLEDGE. I ALSO UNDERSTAND THAT THIS INFORMATION WILL BE HELD IN THE STRICTEST CONFIDENCE, AND IT IS MY RESPONSIBILITY TO INFORM THE OFFICE OF ANY CHANGES IN MY MEDICAL OR DENTAL STATUS.

I AUTHORIZE THE DENTAL STAFF TO PERFORM ANY NECESSARY DENTAL SERVICES THAT I MAY NEED DURING DIAGNOSIS AND TREATMENT WITH MY INFORMED CONSENT.

PATIENT (PARENT/GUARDIAN) SIGNATURE: ________________________________ DATE: ______________

DOCTOR SIGNATURE:____ DATE:______________

OUR OFFICE IS COMMITTED TO MEETING OR EXCEEDING THE STANDARDS OF INFECTION CONTROL MANDATED BY OSHA, THE CDC AND THE ADA.