Dental History

Name: _____ Date _____

It is important that Dr. Arrington and Dr. Scardina know your dental and medical history. Many things have a direct bearing on your dental health. Information you give us is confidential and will not be released to anyone without your written permission.

Are you having any discomfort at this time? [ ] YES [ ] NO
If yes, what is hurting? _____

How often do you brush and / or floss your teeth? _____

How long since you have been to a dentist? _____
What was done then? _____

Did you have X-Rays? [ ] YES [ ] NO
If yes, when? _____

Have you lost any teeth? [ ] YES [ ] NO
If yes, why? _____

Do you want to know how to keep the natural teeth you still have? [ ] YES [ ] NO

Any complications with extractions? [ ] YES [ ] NO

How do you feel about dentures? _____

Are your teeth sensitive to; [ ] Heat [ ] Cold [ ] Sweets

Have you ever had gum treatments? [ ] YES [ ] NO
If yes, when? _____

Do you feel you have had bad breath at times? [ ] YES [ ] NO

Do you have an unpleasant taste in your mouth? [ ] YES [ ] NO

Does food tend to become caught between your teeth? [ ] YES [ ] NO

Are you aware of any swelling or lump in your mouth? [ ] YES [ ] NO

Do you have any fear of having dentistry done? [ ] YES [ ] NO
If yes, why? _____

Do you grind or clench your teeth? [ ] Yes [ ] NO
If yes, when? _____

Are your teeth wearing on the biting surfaces? [ ] YES [ ] NO

Have you ever worn a night guard? [ ] YES [ ] NO

Do you wish your teeth were whiter? [ ] YES [ ] NO

Is there anything you would like to change about your teeth? [ ] YES [ ] NO
If yes, what? _____