KING
DENTAL CENTRE

DENTAL HISTORY

Patient Name: _____ Date: _____

Previous Dentist's Name: _____ Office Phone: _____

Date of your last dental visit: _____ Last Dental Cleaning: _____ Last X-Rays: _____

How often were you seeing your dentist? ❑ Every _____ Months ❑ Yearly ❑ When Needed ❑ Other _____

How often do you brush your teeth? _____ How often do you floss your teeth? _____

What is the reason for today's visit? _____

Please indicate if you have had any of the following treatments:

- ❑ Oral Hygiene Treatment
- ❑ Surgical Treatment/Extraction
- ❑ Partial and/or Complete Denture
- ❑ Crown and/or Bridge
- ❑ Root Canal Treatment
- ❑ Dental Fillings
- ❑ Orthodontic Treatment
- ❑ Gum Treatment
- ❑ Dental Implants
- ❑ X-Rays
- ❑ Bite Adjustment
- ❑ Other _____

	YES	NO
Are you currently having and pain or discomfort?	❑	❑
Do your gums bleed while brushing/flossing or eating?	❑	❑
Do you have sensitive teeth?	❑	❑
❑ Hot ❑ Cold ❑ Sweet ❑ Pressure		
Do you have any pain when you chew?	❑	❑
Have you experienced any pain in the muscles of your face or ear?	❑	❑
Do you have frequent headaches, neck aches or shoulder aches?	❑	❑
Did you ever have any blows to your jaw?	❑	❑
Does your jaw crack or pop?	❑	❑
Does your jaw lock when open or closed?	❑	❑
Do you chew primarily on one side of the mouth?	❑	❑
Does food catch between your teeth?	❑	❑
Do you feel any of your fillings?	❑	❑
Do you breathe through your mouth when sleeping?	❑	❑
Have you been given oral hygiene instructions?	❑	❑
Are you happy with the appearance of your teeth?	❑	❑

DOCTOR'S COMMENTS

Do any of the following problems apply to you?

- ❑ Painful Gums
- ❑ Swollen Gums
- ❑ Grinding/Clenching
- ❑ Nail/Pen Biting
- ❑ Mouth Growths
- ❑ Gag Easily
- ❑ Tooth Ache/Pain
- ❑ Loose Teeth
- ❑ Lip/Cheek Biting
- ❑ Mouth Sores
- ❑ Bad Breath
- ❑ Broken Teeth

Check any of the following that me be of interest to you:

- ❑ Braces
- ❑ Closing Spaces Between Teeth
- ❑ Replacing Missing Teeth
- ❑ Repairing Chipped Teeth
- ❑ Improve Gum Health
- ❑ Improving Your Smile
- ❑ Straightening Your Teeth
- ❑ Improving Bite
- ❑ Caps (Crowns)
- ❑ Whitening Teeth
- ❑ Improving Breath Odor
- ❑ Other _____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

Patient or Parent/Guardian Signature: _____ Date: _____

Treating Dentist's Signature: _____ Date: _____