DENTAL HISTORY & QUESTIONNAIRE

CHILDREN'S QUESTIONS:

Has your child had a previous dental visit

___Yes ___No If yes, please provide name & address.

Was this visit: Pleasant___ Okay___ or Traumatic___

Has your child had:

___A Local Anesthetic (Shot)

___Nitrous Oxide (Gas)

___Dental Sealants

___Fluoride Treatment

___Fluoride Supplements to Diet

Do you use well water? ___Yes ___No

Does your child:

___Suck Thumb or Finger

___Mouthbreathe

___Snore

ADULT'S QUESTIONS:

When was the last time you saw a dentist? _____

Did you have any of the following completed:

___Examination ___Cleaning

___Filling ___Extraction

___X-rays

What is the name and address of your previous dentist:

_____

_____

_____

May we obtain copies of your records and radiographs?

___Yes ___No

Do you have any of the following:

___Bad Breath

___Bad Taste

___Bleeding or Sore Gums

___Loose Teeth

___Toothache

___Ulceration, Swelling or sore

___Sensitivity to Hot or Cold or upon biting

Does your jaw:

___Click or pop when opening or closing

___Lock open or closed

___Have muscle tenderness

Do you grind your teeth at night, or clench excessively?

___Yes ___No

Have you ever been instructed by a dentist or hygienist in proper

___brushing ___flossing

Are you pleased with the shape or position of your teeth?

___Yes ___No

Do you like your smile? ___Yes ___No

Are you pleased with the shade of your teeth? ___Yes ___No

Do you notice the color of your fillings? ___Yes ___No

Do you wear complete or partial dentures?

___Yes ___No If so, for how long? _____

Do you have a specific problem that we need to be made aware of?

___Yes ___No If so, what _____

_____