

Bridgeview Dental Associates

Dental History

Name of Previous Dentist: _____ Date of Last Exam: _____

Date of Last X-rays: _____ Date of Last Cleaning: _____

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

Do your gums bleed while brushing or flossing? y__ n__

Have you ever been treated for periodontal (gum) disease? y__ n__

Do you have sore or painful teeth? y__ n__

Do you have broken or chipped teeth? y__ n__

Do you have lost or broken fillings? y__ n__

Have you had orthodontic treatment (braces)? y__ n__

Do you have a dry mouth? y__ n__

Do you have any swelling or lumps in your mouth? y__ n__

Do you clench or grind your teeth? y__ n__

Do you have clicking, popping, or pain in your jaw? y__ n__

Are you nervous about dental treatment? y__ n__

Do you require pre-medication? y__ n__

If yes, what medication? _____

Have you had previous complications from dental treatment? y__ n__

If yes, please explain: _____

Chief Complaint/Reason for Visit: _____

Are you happy with the appearance of your smile? _____

Is there anything you would like to change about the appearance of your teeth? _____

Would you be interested in learning how your smile may be enhanced? _____

Special concerns we should know about: _____

Signature: _____ Date: _____