

Dentistry at Windermere

2964 Buford Hwy., Suite #200
Cumming, GA 30041
Phone (770) 205-1212

Welcome! So that we may provide you with the best possible care, please complete this dental history form. All information is kept confidential.

Dental History

Date: _____ Name: _____

Date of last dental visit: _____

Last full set of xrays: _____

How often do you brush your teeth? _____

What type of brush? Soft Medium Hard Electric

What other dental aides do you use? ___ Water Pik
___ Mouthwash

Preferred Name: _____

Date of Last Cleaning: _____

How often do you floss? _____

___ Toothpicks ___ Fluoride Rinse
___ Other _____

Have you ever had:

Othodontic Treatment (Braces) Yes ___ No ___
Endodontic Treatment (Root Canal) Yes ___ No ___
Oral Surgery (Extractions) Yes ___ No ___
Gum Surgery Yes ___ No ___
Deep Cleaning Yes ___ No ___

Do your gums hurt or bleed Yes ___ No ___
Any mouth odor or bad taste Yes ___ No ___
Do you have loose teeth Yes ___ No ___
Any change/shift in your bite Yes ___ No ___
Food catching between teeth Yes ___ No ___
Serious injury to your mouth/head Yes ___ No ___
If yes, please describe: _____

Are any of your teeth sensitive to:

Hot Cold Sweet Biting/Chewing

What is the reason for your visit today?

Do you feel nervous about having dental treatment?

Yes ___ No ___ If yes, explain: _____

Cold sores Yes ___ No ___
Frequent canker sores Yes ___ No ___
Smoke or chew tobacco Yes ___ No ___
Mouth breathe while awake/asleep Yes ___ No ___
Bite your lips or cheek Yes ___ No ___
Teeth Whitening/Bleaching Yes ___ No ___

Do you grind or clench your teeth Yes ___ No ___
Do you wear a mouth guard Yes ___ No ___
Occlusal bite adjusted Yes ___ No ___

Have you ever experienced:

Clicking or popping of the jaw Yes ___ No ___
Pain (jaw, ear, side of face) Yes ___ No ___
Difficulty opening/closing mouth Yes ___ No ___
Difficulty chewing Yes ___ No ___
Tired jaws, especially in morning Yes ___ No ___
Frequent Headaches Yes ___ No ___
Excess stress at home/work Yes ___ No ___