DENTISTRY AT

WINDERMERE

# Dental History

Welcome! We are so glad that you are here. Please complete this dental history form so that we may provide you with the best possible care. All information is kept confidential.

Date:_____ Name:_____

Reason for your visit today?_____

_____

_____

**Approximate Date of:**

Last Dental Exam: _____ Last Cleaning:_____ Full Set of X-rays: _____

Dental Anxiety Level: ☐Low ☐Normal ☐High

What kind tooth brush do you use? ☐Manual ☐Electric What type? ☐Soft ☐Medium

Do you use any other dental aids? (check all that apply) ☐Water Pik ☐Toothpicks ☐Fluoride rinse

☐Mouth Wash ☐Other_____

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

Are any of your teeth sensitive to: (check all that apply) ☐Hot ☐ Cold ☐Sweets ☐Chewing /Pressure

**Have you ever had *(check all that apply):***

☐ Orthodontic treatment/Braces

☐ Endodontic treatment/Root Canal

☐ Extractions/Oral Surgery

☐ Gum Surgery

☐ Bite Lips or Cheeks

☐ Scaling and root planning/Deep Cleaning

☐ Cold Soar/Fever Blister

☐ Frequent Canker Soars

☐ Smoke Tobacco

☐ Chew Tobacco

☐ Occlusal or Bite adjustment

☐ Teeth Whitening/Bleaching

☐ Clicking or Popping of the Jaw

☐ Pain in Ear, Jaw or Face

☐ Difficulty Opening or closing mouth

☐ frequent Headaches

☐ Excessive Stress

**Check any that apply to you:**

☐ Bleeding or Painful Gums

☐ Bad taste in your mouth

☐ Loose Teeth

☐ Wear Night guard

☐ Food Catching between your Teeth

☐ Clench/grind teeth

Signature: _____ Date:_____

(Patient/Parent or Guardian)