

**Dentistry at Windermere
2964 Buford Highway St. 200
Cumming, Georgia 30041
770-205-1212**

Dental History

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

Print name:
wished to be
called:
Date of last dental visit:
(to any office)
Date of last dental
cleaning:
Date of last full mouth
x-rays:

Previous Dentist Info

Name:
Phone:
Address:
City:
State:
Zip:

How often do you brush your teeth?
What type of brush? Soft Medium Hard
How often do you floss?
What other dental aides do you use?
Electric Toothbrush
Toothpick
Fluoride Rinse
Other

Have you ever had:	(Circle One)
Orthodontic treatment (Braces)	Yes No
Endodontic treatment (root canal)	Yes No
Oral Surgery (extractions)	Yes No
Periodontal treatment (gums)	Yes No
Gum Surgery	Yes No
Gingival grafts	Yes No
Do your gums hurt/bleed	Yes No
Any mouth odor or bad taste	Yes No
Wear a mouth plate or mouth guard	Yes No
Any loose teeth	Yes No
Change/shift in your bite	Yes No
Food caught in between teeth	Yes No
If yes, where?	
A serious injury to mouth or head	Yes No
If yes, please describe including the cause	

Any of your teeth sensitive to:	
Hot or cold	Yes No
Sweets	Yes No
Biting or chewing	Yes No

Do you:	(Circle One)
Frequently get cold sores	Yes No
Blisters or any other oral lesions	Yes No
Clinch or grind your teeth awake or asleep	Yes No
Bite your lips or cheek regularly	Yes No
Hold foreign objects with your teeth	Yes No
Mouth breathe while awake or asleep	Yes No
Smoke/chew tobacco	Yes No

Have you ever experienced:	
Occlusal equilibration/bite adjusted	Yes No
Clicking or popping of the jaw	Yes No
Pain (joint, ear, side of face)	Yes No
Difficulty in opening/closing the mouth	Yes No
Difficulty chewing either side of mouth	Yes No
Tired jaws, especially in mornings	Yes No
Frequent headaches	Yes No
Sore neck and/or shoulder muscles	Yes No
Excess stress/ pressure at work/home	Yes No
If so, please describe:	

What is your reason for your visit today:

Do you feel nervous about having dental treatment? Yes__No__ If yes, explain:

How do you feel about the appearance of your teeth?