DENTAL HISTORY
Grin and Bear It Family Dental Center

NAME ______________________________ DATE ______________

What is your reason for seeking dental treatment at this time? Routine checkup ☐ Special Problem ☐

Please explain any concerns: ______________________________

When was your last dental examination? ______________________________

Name of your previous dentist? ______________________ City ______________

Have you ever had any serious trouble associated with previous dental treatment? ______________

Please explain ______________________________

Does dental treatment make you nervous? No ☐ Slightly ☐ Moderately ☐ Very Much ☐

How can we make your appointment more comfortable? ______________________________

Do you have difficulty becoming numb? Yes ☐ No ☐

Do you want to keep your natural teeth throughout your lifetime? Yes ☐ No ☐ Don't know ☐

Are you taking - fluoride tablets, fluoride vitamins, using fluoride mouth wash, or have fluoridated water? Yes ☐ No ☐

How often do you miss your Medical or Dental appointments? I Would Never Think of It ☐ Sometimes ☐ Often ☐

ORAL HYGIENE:

How many times do you brush your teeth? Daily____ Weekly_____

How many times do you floss your teeth? Daily____ Weekly_____

How often do you notice bleeding after brushing or flossing?

Often ☐ Seldom ☐ Never ☐

Other comments ______________________________

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NUTRITION

Do you frequently consume sugar such as gum, soda pop, life savers, or candy bars, etc.?

Yes ☐ No ☐

Do you drink coffee or tea? Yes ☐ No ☐

With Sugar? ☐ Without Sugar? ☐