Bowers and Oki Family Dentistry

Patient Dental History

Patient's Name_____ Date of Birth_____

What is the reason for your visit today?_____

When was your last dental visit? _____What was done?_____

How often did you visit the dentist before then_____

Previous dentist (Name and Location)_____

When were your last x-rays taken?_____

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

Is your drinking water fluoridated?_____

	YES	NO	IF YES, EXPLAIN
Do your gums bleed or hurt?	___	___	_____
Are your teeth sensitive to hot, cold, sweets, or pressure?	___	___	_____
Do you feel pain on any of your teeth?	___	___	_____
Do you have any sores or lumps in or near your mouth?	___	___	_____
Have you had any head/neck injuries?	___	___	_____
Have you ever experienced any of the following problems with your jaw?			
Clicking or Popping	___	___	_____
Pain (joint, ear, side of face)	___	___	_____
Difficulty Opening or closing	___	___	_____
Difficulty Chewing	___	___	_____
Do you have frequent headaches?	___	___	_____
Have you experienced pain in the muscles of your face or around your ear?	___	___	_____
Do you clench or grind your teeth?	___	___	_____
Do you bite your lips or cheeks frequently?	___	___	_____
Have you noticed any loosening of your teeth?	___	___	_____
Does food tend to become caught between your teeth?	___	___	_____
Have you ever had periodontal (gum) treatment/surgery?	___	___	_____
Have you ever had any teeth removed?	___	___	_____
Have you had any teeth replaced (bridges, implants, dentures)?	___	___	_____
If Yes, are you happy with them?	___	___	_____
If No, are you interested in discussing replacement options?	___	___	_____
Have you ever had any problems/complications from previous dental treatment?	___	___	_____
Have you had any orthodontic work?	___	___	_____
Do you feel your breath is offensive at times?	___	___	_____
Are you unhappy with the appearance of your teeth?	___	___	_____

Do you have any questions or concerns_____

_____

_____

_____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND CORRECT

Patients/Guardians Signature_____Date_____