WELCOME TO PARK CITIES FAMILY DENTISTRY

NAME: _____
DATE OF BIRTH:

PURPOSE OF INITIAL VISIT?_____
HOW LONG SINCE YOUR LAST VISIT?_____
WHEN WAS THE LAST TIME YOUR TEETH WERE CLEANED?_____

CIRCLE THE APPROPRIATE ANSWER

Have you made regular visits?	YES	NO
How Often?_____		
Were dental x-rays taken?	**YES**	**NO**
Have you lost any teeth or have any teeth been removed?	YES	NO
Have they been replaced?	**YES**	**NO**
How were they replaced and what was the date of replacement?		
Fixed Bridge_____ **Date_____**		
Removeable Bridge_____ Date_____		
Denture_____ **Date_____**		
Implant_____ Date_____		
Are you happy with the replacement?	**YES**	**NO**
Would you like to know more about permanent replacements?	YES	NO
Have you had or are you experiencing complications with previous treatment?	**YES**	**NO**
Do you clench or grind your teeth?	YES	NO
Does your jaw click or pop?	**YES**	**NO**
Have you experienced pain/soreness in the muscles or face around your ear?	YES	NO
Do you have frequent headaches, neckaches, or shoulder aches?	**YES**	**NO**
Does food get caught in your teeth?	YES	NO
Are any teeth sensitive to: ☐ ***HOT?*** ☐ ***COLD?*** ☐ ***SWEETS?*** ☐ ***PRESSURE?***		
Do your gums bleed or hurt?	YES	NO
Do you experience dry mouth?	**YES**	**NO**
Do you use dental floss?	YES	NO
How often?_____		
Are any teeth loose, tipped, shifted or chipped?	**YES**	**NO**
Are you unhappy with the appearance of your teeth?	YES	NO
How do you feel about your teeth in general?	**YES**	**NO**
Do you feel your breath is offensive at times?	YES	NO
Have you ever had gum treatment or surgery?	**YES**	**NO**
What procedure?_____		
Date?_____		
Have you had orthodontic treatment?	**YES**	**NO**
Dates?_____		
Do you have any specific concerns or apprehensions today?_____		

Patient Signature_____DATE:_____

DENTAL HISTORY