

## Davis and Dingle Family Dentistry Patient Dental History

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

	<u>Yes</u>	<u>No</u>
1. Are your teeth sensitive to: Heat? Cold? Sweets? Biting Pressure?	_____ _____ _____ _____	_____ _____ _____ _____
2. Does food constantly get stuck between certain teeth?	_____	_____
3. Do you get frustrated because you always have something to be treated or repaired when you visit a dentist?	_____	_____
4. Are you dissatisfied with your teeth in any way?	_____	_____
5. Are you dissatisfied with the way your teeth look? i.e., color, shape, spaces, etc.	_____	_____
6. Do you have any fillings that show in your front teeth?	_____	_____
7. Do any of your fillings show when you smile?	_____	_____
8. If any of your mercury amalgam fillings need replacement, would you prefer to have a more natural, tooth-colored restoration instead?	_____	_____
9. Have you ever had any teeth removed? (If Yes, how long have these teeth been missing?)	_____ _____	_____ _____
10. Do your gums bleed when brushing?	_____	_____
11. Do you ever avoid any part of the mouth while brushing?	_____	_____
12. Do you have an unpleasant taste or odor in your mouth?	_____	_____
13. Do you smoke?	_____	_____
14. How often do you floss?	_____	
15. Have you been instructed regarding proper home care?	_____	_____

REMARKS:

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