

DENTISTRY AT HICKORY FLAT

Dental History

Welcome! We are so glad that you are here. Please complete this dental history form so that we may provide you with the best possible care. All information is kept confidential.

Date: _____ Name: _____

Reason for your visit today? _____

Approximate Date of:

Last Dental Exam: _____ Last Cleaning: _____ Full Set of X-rays: _____

Dental Anxiety Level: Low Normal High

What kind tooth brush do you use? Manual Electric What type? Soft Medium

Do you use any other dental aids? (Check all that apply) Water Pik Toothpicks Fluoride rinse

Mouth Wash Other _____

How often do you brush? _____ How often do you floss? _____

Are any of your teeth sensitive to: (check all that apply) Hot Cold Sweets Chewing /Pressure

Have you ever had (check all that apply):

- | | | |
|--|--|--|
| <input type="checkbox"/> Orthodontic treatment/Braces | <input type="checkbox"/> Cold Soar/Fever Blister | <input type="checkbox"/> Clicking or Popping of the Jaw |
| <input type="checkbox"/> Endodontic treatment/Root Canal | <input type="checkbox"/> Frequent Canker Soars | <input type="checkbox"/> Pain in Ear, Jaw or Face |
| <input type="checkbox"/> Extractions/Oral Surgery | <input type="checkbox"/> Smoke Tobacco | <input type="checkbox"/> Difficulty Opening or closing mouth |
| <input type="checkbox"/> Gum Surgery | <input type="checkbox"/> Chew Tobacco | <input type="checkbox"/> frequent Headaches |
| <input type="checkbox"/> Bite Lips or Cheeks | <input type="checkbox"/> Occlusal or Bite adjustment | <input type="checkbox"/> Excessive Stress |
| <input type="checkbox"/> Scaling and root planning/Deep Cleaning | <input type="checkbox"/> Teeth Whitening/Bleaching | |

Check any that apply to you:

- | | |
|---|---|
| <input type="checkbox"/> Bleeding or Painful Gums | <input type="checkbox"/> Wear Night guard |
| <input type="checkbox"/> Bad taste in your mouth | <input type="checkbox"/> Food Catching between your Teeth |
| <input type="checkbox"/> Loose Teeth | <input type="checkbox"/> Clench/grind teeth |

Signature: _____

(Patient or Parent/Guardian)

Date: _____