FAIRBURY SMILE DESIGNS
DENTAL HISTORY

Patient Name: _____ Date of Birth: ____/____/_____

Please describe your chief oral complaint:

_____

_____

_____

Are your teeth sensitive to:	YES	NO
Heat?	____	____
Cold?	____	____
Sweets?	____	____
Chewing?	____	____
Do you have any food traps?	____	____
Do your gums ever feel tender or swollen?	____	____
Do your gums bleed when brushing?	____	____
Do you have any teeth that feel loose?	____	____
Have you been treated for periodontal disease?	____	____
Do you use dental floss?	____	____
Have you had any injuries to your face or jaw?	____	____
Have you ever had your teeth straightened/braces?	____	____
Do you clench or grind your teeth?	____	____
Do you strike some teeth before others when closing?	____	____
Have you ever had your bite adjusted?	____	____
Do your jaws ever feel tired or ache?	____	____
Can you chew comfortably?	____	____
Have you had a complete dental exam including full mouth x-rays in the past 3 years?	____	____
Do you have your teeth cleaned regularly?	____	____
Do you have all of your natural teeth?	____	____
Would you like to keep your natural teeth?	____	____
Are missing teeth replaced?	____	____
Do you like the appearance of your smile?	____	____
Do you consider yourself a nervous patient?	____	____
Have you ever had a bad dental experience?	____	____
Have you ever had issues with local anesthetics?	____	____

Physician's Name _____ Phone# _____

Last visit to physician ____/____/_____ Last complete physical ____/____/_____

When was your last dental visit? ____/____/_____ Last Cleaning ____/____/_____

What was done at that visit? _____

_____

Where was it done? _____

If you could change your teeth/smile, how would you? _____

_____

_____