Riverside Heights Dental Centre

Patient Dental History

Patient's name _____ Date of Birth _____

Date of last dental visit _____Treatment provided at that time_____

Frequency of dental visits _____

Previous Dentist (name/location) _____

Please indicate Yes (Y) or No (N) to the following:

Do your gums bleed while brushing or flossing? ___
Are your teeth sensitive to hot or cold? ____
Are your teeth sensitive to sweet or sour? ____
Do you feel pain in any of your teeth? ____
Do you have any sores or lumps in or near your mouth? ____
Have you ever had any head, neck or jaw injury? ____
Have you ever experienced any of the following problems in your jaw? Please circle
Clicking, Pain (joint, ear or side of face), Difficulty in opening/closing, Difficulty in chewing?
Do you have frequent headaches? ____
Do you clench or grind your teeth? ____
Do you bite your lips/cheeks frequently? ____
Have you noticed any loosening of your teeth? ____
Does food get caught between your teeth? ____
Have you had periodontal (gum) treatment?
Have you received oral hygiene instruction for the care of your teeth and gums? ____
Have you had difficult extractions before? ____
Have you had prolonged bleeding following extractions before? ____
Do you wear dentures or partials? _____
Do you have dental implants? If yes, date of placement_____

Have you had orthodontic treatment? If yes, date of completing_____

Have you had treatment from a dental specialist? If yes, what type?_____

Additional comments or concerns? _____
_____
_____

Patients Signature: _____ Date : _____