

DENTAL HISTORY & QUESTIONNAIRE



CHILDREN'S QUESTIONS:

Has your child had a previous dental visit

Yes No If yes, please provide name & address.

Was this visit: Pleasant Okay or Traumatic

Has your child had:

A Local Anesthetic (Shot)

Nitrous Oxide (Gas)

Dental Sealants

Fluoride Treatment

Fluoride Supplements to Diet

Do you use well water? Yes No

Does your child:

Suck Thumb or Finger

Mouthbreathe

Snore

Do you have any of the following:

Bad Breath

Bad Taste

Bleeding or Sore Gums

Loose Teeth

Toothache

Ulceration, Swelling or sore

Sensitivity to Hot or Cold or upon biting

Does your jaw:

Click or pop when opening or closing

Lock open or closed

Have muscle tenderness

Do you grind your teeth at night, or clench excessively?

Yes No

Have you ever been instructed by a dentist or hygienist in proper

brushing flossing

Are you pleased with the shape or position of your teeth?

Yes No

Do you like your smile? Yes No

Are you pleased with the shade of your teeth? Yes No

Do you notice the color of your fillings? Yes No

Do you wear complete or partial dentures?

Yes No If so, for how long? _____

Do you have a specific problem that we need to be made aware of?

Yes No If so, what _____



ADULT'S QUESTIONS:

When was the last time you saw a dentist? _____

Did you have any of the following completed:

Examination Cleaning

Filling Extraction

X-rays

What is the name and address of your previous dentist:

May we obtain copies of your records and radiographs?

Yes No