Westbank Dental

DENTAL HISTORY FORM

Patient Name_____ DOB _____ Date _____

Previous Dentist _____ How long were you a patient? _____

Date of most recent dental exam _____ Date of most recent x-rays _____

Date of most recent treatment (other than cleaning) _____

I routinely see my dentist every: ○ 3 months ○ 4 months ○ 6 months ○ 12 months ○ Not routinely

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Please describe the primary reason for your visit (concerns):

1. _____
2. _____
3. _____

How long has this been going on and what would you like done?

_____

_____

If you could rate your smile from 1-10, what would it be? _____

Would you like to improve your smile? Yes No How? _____

_____

Would you like to straighten your teeth with Invisalign?	Yes	No
Have you ever whitened your teeth?	Yes	No
If no, would you like them whiter?	Yes	No
Do you have problems with your jaw joints? (i.e. pain, popping, clicking, locking, limited opening?	Yes	No
Do you clench or grind your teeth in the daytime or when you sleep?	Yes	No
Do you wear or have you ever worn a bite appliance?	Yes	No
Have you had any cavities in within the past three years?	Yes	No
Have you ever had trouble getting numb or had any reactions to local anesthetic (Novocaine)?	Yes	No
Does your mouth ever feel dry, or do you feel like you have too little saliva?	Yes	No
Are your teeth sensitive to hot, cold, sweets, or brushing?	Yes	No
Do your gums bleed when you brush or floss?	Yes	No
Have you ever been diagnosed with or treated for periodontal (gum) disease?	Yes	No

How often do you brush your teeth everyday? _____ floss? _____

What type of toothbrush do you use? Soft Medium Hard Electric

I certify that the above information is complete and correct.

Patient's Signature_____ Date: _____

Doctor's Signature _____ Date: _____