BROOKSIDE DENTISTRY

Luke A. Foster, DDS
Chia-Yin Lo, DDS

Dental History

Patient Name_____ Date of Birth _____

Date of most recent dental exam (if known) _____ Date of most recent dental x-rays (if known)_____

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

How often do you drink pop/energy drinks/sugared beverages? _____

Y N Do you have sensitive teeth?

☐ Hot ☐ Cold ☐ Sweets ☐ Pressure/chewing

Y N Have you ever been treated for periodontal disease (gum disease)?

Y N Do your gums bleed when you brush/floss/chew?

Y N Do you have any loose teeth?

Y N Are you aware of any swelling or lumps in your mouth?

Y N Have you had orthodontics (braces)?

Y N Do you wear a removable retainer or night guard?

Y N Have you had your wisdom teeth removed?

Y N Do you clench or grind your teeth?

Y N Do you experience jaw pain/soreness/clicking/popping?

Y N Is there anything about the appearance of your teeth that you would like to change?

Y N Are you interested in tooth whitening?

Y N Are you fearful of dental treatment?

Y N Have you had an unfavorable dental experience?

Y N Have you ever had trouble getting numb or had any reactions to local anesthetic?

Is there anything else you would like us to know? _____

_____

Patient signature _____ Date _____