FLORESTA PLAZA DENTAL

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DENTAL HISTORY FORM

Patient:_____

Name of Former Dentist:_____ Date of Last Dental Exam:_____

Address of Former Dentist:_____ Phone:_____

Physician's name:_____ Last Physical Exam:_____

Circle Appropriate Answer (leave blank if you do not understand the question)

1. May we send for your dental records? Yes/ No
2. Have you had a major dental treatment during the past 5 years? Yes/ No
   If so, What?_____
3. Are you aware of any changes in your dental health during the last year? Yes/ No
4. What is the primary purpose of this visit?_____
5. What did you **like** about your previous dentist?_____
6. What did you **not like** about your previous dentist?_____
7. What is your major concern in regard to your dental treatment?_____
   _____
8. How many times a day do you brush your teeth?_____Floss your teeth?___
9. Have you ever had any of the following:
   Orthodontics/Oral Surgery/Periodontal Surgery/Root canals
10. Do you have any of the following: please. circle
    Bleeding gums/ bad breath/ Dry mouth/ Pain on chewing/ Jaw joint problems
11. Are any of your teeth sensitive to: Hot/ Cold/ Sweets/ Pressure
12. Do you have any problems with dental anesthetic? Yes/ No
13. Are you happy with the appearance of you smile? Yes/ No
    If no, please explain:_____

Signature:_____ Date:_____