

Avondale Dental Center Dental History

PLEASE CIRCLE or FILL IN WITH THE APPROPRIATE INFORMATION

- Yes No** 1. Are you in dental discomfort today?
If so, explain: _____
2. How long has it been since your last teeth cleaning? _____
3. How long has it been since your last dental treatment? _____
4. What was done at that time? _____
5. When were x-rays last taken? _____
6. What do you need to be more comfortable or relaxed during dental visits? _____
- Yes No** 7. Have you ever had any serious trouble associated with any previous dental treatment?
If so, explain: _____
- Yes No** 8. Do you clench or grind your teeth?
- Yes No** 9. Have you ever had any unfavorable reaction from a dental anesthetic?
If so, explain: _____
- Yes No** 10. Are any of your teeth sensitive? (*check if applicable*)...
- hot _____
- cold _____
- sweets _____
- pressure _____
- Yes No** 11. Do you use tobacco? If so, type and amount: _____
12. Have you seen a dental specialist or had any of the following treatment? (*check if applicable*)...
- Orthodontic (braces) _____
- Endodontic (root canal filling) _____
- Periodontic (gum disease) _____
- Oral Surgeon (extractions) _____
- Other _____
13. What would you change, if anything, about the appearance of your teeth and smile? (*check if applicable*)...
- Color _____
- Shape _____
- Crowding _____
- Missing Teeth _____
- Other _____