

# Patient Dental History

Sparkle Dental Hygiene Clinic

[1.0] NEW PATIENT

When was your last dental visit? \_\_\_\_\_

When did you last have dental x-rays taken? \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_

How often do you floss? \_\_\_\_\_

	Yes	Don't Know or N/A:	No
Have you been seeing a dentist regularly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do any of your teeth ache?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been advised to take antibiotics before dental appointments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed when you brush?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any pain when you chew?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel that you have bad breath?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been in a vehicle accident or experienced any trauma to your jaw?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any implant surgery ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answered yes to the last question, who performed the surgery and when was it done?  
\_\_\_\_\_ Date \_\_\_\_\_

Are you being followed-up by a dental specialist? \_\_\_\_\_

Do you have any problems with your jaw joint (pain, sounds, limited opening, locking, popping)?  Yes  Don't Know or N/A  No

Is there anything about the appearance of your teeth you would like to change? \_\_\_\_\_

Please list anything not mentioned above regarding your past dental history:  
\_\_\_\_\_  
\_\_\_\_\_