BAYVIEW DENTAL ASSOCIATES, P.A. DENTAL HISTORY

Patient Name:			Date:	
	VEC.	NO		
Are you having any discomfort or problems at this time?	YES	NO		
If so, what problems?				-
How long since you have been to a dentist?				
What was done at your last visit?				
Did you have x-rays?				
Date of last full mouth x-rays				
Name of your previous dentist				
Address of your previous dentist				
Have you lost any teeth?	YES	NO		
Why were the teeth lost?				
Have they ever been replaced?	YES	NO	,	
Are your teeth sensitive to				
heatcoldsweetspressure			-	÷
Do you have problems with teeth/fillings breaking?	YES	NO		
Have you ever had your teeth straightened?	YES	NO	When?	
Do you have any loose, tipped or shifting teeth? (circle)				
How often do you brushfloss		?		
Do you use any other cleaning aids or rinses?	YES	NO		
If so, what type			- 	
Do your gums bleed?	YES	NO	When?	/
Have you ever had gum treatments?	YES	NO	When?	
Do you have any pain, clicking or popping noises in your jaw joint?	YES	NO		
Are you aware of grinding or clenching your teeth?	YES	NO		
Have you ever had TMJ treatment?	YES	NO		
Do you have any lump or swelling in your mouth?	YES	NO		
Do you have any fear of having dentistry done?	YES	NO		
If yes, why?			, ,	
Have you ever had an unusual reaction to local anesthesia?	YES .	NO		
Have you ever had any complications following dental treatment?	YES	NO	Explain:	
Are you satisfied with the appearance of your teeth?	YES	ŇO		

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