Barnett Family Dentistry
Dental History

Patient Name:_____

What is the reason for today's visit?_____

Former Dentist:_____

Date of last dental visit:_____ Date of last dental x-rays:_____

1. Are you having any specific problems with your teeth, gums, or mouth?..... yes / no
2. Are your teeth sensitive to hot?.....yes / no
3. Are your teeth sensitive to cold?.....yes / no
4. Are your teeth sensitive to sweets?.....yes / no
5. Are your teeth sensitive when you bite?.....yes / no
6. Do you clench or grind your teeth?..... yes / no
7. Do you have any broken teeth or fillings?.....yes / no
8. Do you get food caught in between your teeth?..... yes / no
9. Do you notice any popping, clicking, or soreness in your jaw?..... yes / no
10. Do your gums bleed after brushing?..... yes / no
11. Do you have any loose teeth?..... yes / no
12. Do you have any sores or growths on your lips or in your mouth?.....yes / no
13. Do you have a problem with bad breath?..... yes / no
14. Do you like your smile?..... yes / no
15. Have you ever worn braces to straighten your teeth?.....yes / no
16. Have you had your wisdom teeth removed?..... yes / no
17. Do you use any tobacco products?..... yes / no
18. Have you ever had a bad experience at the dentist?..... yes / no

How often do you brush?_____

How often do you floss?_____

Do you use a hard, medium, or soft toothbrush? (Please circle)

PATIENT/GUARDIAN SIGNATURE:_____ DATE:_____

REVIEWED WITH PATIENT BY:_____ DATE:_____