

PRINCETON PARK DENTAL ASSOCIATES, P.A.
CONFIDENTIAL DENTAL HISTORY

Name _____

What is the reason for your present visit? _____

When was your last visit to the dentist? _____

How often do you visit the dentist for regular check-ups? _____

When did you last have dental x-rays? _____

PLEASE CIRCLE THE ANSWER THAT BEST APPLIES TO YOU

- | | | |
|-----|----|--|
| Yes | No | Do you have any sensitivity due to hot, cold or sweet foods? |
| Yes | No | Do you have any pain while biting or chewing? |
| Yes | No | Does food catch between your teeth? |
| Yes | No | Do you clench or grind your teeth during the day or night? |
| Yes | No | Do you have frequent headaches or neck pains? |
| Yes | No | Do you ever wake up with sore facial muscles? |
| Yes | No | Have you ever had pain, clicking or soreness of the jaw joints? |
| Yes | No | Have you had orthodontic treatment? |
| Yes | No | Have you ever had any surgery on your face, gums or mouth? |
| Yes | No | Do your gums feel irritated, tender or swollen? |
| Yes | No | Do your gums bleed when chewing or brushing? |
| Yes | No | Do you have an unpleasant taste in your mouth? |
| Yes | No | Have you been instructed in caring for your teeth and gums? |
| Yes | No | Have you had any teeth replaced by bridges, partials or dentures? |
| Yes | No | Do any of your family members have periodontal (gum) disease? |
| Yes | No | Do you play any contact sports? |
| Yes | No | Have you been told that you snore or make snoring noises at night? |
| Yes | No | Are you tired all the time? |

SMILE EVALUATION

- | | | |
|-----|----|---|
| Yes | No | Do you like the appearance of your teeth, your smile?
If not, explain: _____ |
| Yes | No | Do you have spaces that you don't like? |
| Yes | No | Do you like the color of your teeth? |

What would you like to change the most in the appearance of your teeth? Please explain:

CHILD'S DENTAL HISTORY

- | | | |
|-----|----|---|
| Yes | No | Is this your child's first visit to the dentist? |
| Yes | No | Has your child ever bumped a front tooth or teeth? |
| Yes | No | Does your child suck his or her thumb or fingers? |
| Yes | No | Has your child ever taken a bottle with milk or juice to bed? |

Did your child's teeth erupt EARLY or LATE? (Circle one)

Is there anything else you feel we should know about your child? _____
