FIFE DENTAL CARE

**Dental History, Concerns, and Goals**

First Name_____ Last Name_____ MI_____ DOB_____

What is the reason for your visit today?

Date of Last Dental Visit_____ Last Dental Cleaning_____ Last Full Mouth X-rays_____

What was done at your last dental visit?_____

How often do you have dental examinations?_____

How often do you brush your teeth?_____ What type of brush do you use? __soft __medium __hard

How often do you floss?_____

What other dental aids do you use? (Interplak, toothpicks, etc)_____

Does dental treatment make you nervous? __no __slightly __moderately __extremely

Please mark any of the following dental conditions you have currently or have had in the past:

__bleeding/sore gums
__unpleasant taste, bad breath
__burning tongue or lips
__frequent blisters, mouth/lip
__orthodontic treatment (braces)
__biting cheeks or lips
__difficulty opening or closing jaw
__periodontal (gum) disease
__loose teeth
__heat sensitivity
__cold sensitivity
__sugar sensitivity
__biting sensitivity
__food impaction
__clenching/grinding
__shifting or change in bite

Please mark any of the following conditions or issues you have had during the last year because of your teeth, mouth, or dentures:

__painful aching anywhere in your mouth
__avoidance of particular foods
__sense of taste affected
__discomfort while eating
__self-conscious or embarrassed
__difficulty doing usual jobs or attending school
__felt that life in general was less satisfying

What are your main dental concerns?_____

_____

What are your dental health goals?_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in dental health status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____

DATE _____