

DENTAL HISTORY

Cedar Hills Dental Center

10976 Cedar Lake Road
Minnetonka, MN 55305
(952) 544-2225
CedarHillsDentalCenter.com

Why have you come to the dentist today? _____
When was your last dental visit? _____ Name of previous dentist or clinic: _____
What do you think your current dental health is? Good Fair Poor
Do you think you have active decay gum disease neither
Is anything bothering you/causing pain? _____

How often do you brush? _____ Floss? _____
What type toothpaste are you using? _____ What type of mouthwash? _____
What type of toothbrush do you use? Manual Electric If an electric brush, what type? _____
What type of bristle does your toothbrush have? Soft Medium Hard
Have you received instructions on the care of your teeth and gums? Yes No

Are your teeth sensitive to: hot/cold sweet sour biting/chewing
Have you ever had : braces bite guard bite adjustment gum treatment
 oral surgery serious head or neck injury
Please check if you: clench or grind your teeth bite your nails
 bite your cheek or tongue frequently chew or suck on a finger/ thumb
 often push your teeth with your tongue often use toothpicks
 cannot easily breathe through your nose catch food between your teeth
 have loose teeth have sores/lumps in your mouth
 have tender or swollen gums bleed when brushing/flossing
 use tobacco products * chew gum drink soda eat candy
*If yes, please check which type: pipe cigar smokeless cigarettes
Would you like information on how to quit? yes no

Have you ever experienced any of the following problems in your jaw?
 Clicking Difficulty opening/closing Difficulty chewing Pain-where: _____
Do your jaws ever get tired? Yes No
Do you get frequent headaches? Yes No
If you wear dentures or partials when did you receive them? _____

Do you like your smile? Yes No Share any details: _____
Would you like a whiter, brighter smile? Yes No
Have you ever felt like your breath isn't fresh? Yes No
What is most important to you regarding your dental visit today? _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

I authorize dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature of patient / Parent or Guardian if patient under 18 year of age

Date

Relationship to patient : _____