

# WOODSTOCK DENTAL

## DENTAL HISTORY

1. You are here today for: Check-up:\_\_\_\_\_ Cleaning:\_\_\_\_\_ Toothache:\_\_\_\_\_

Chief Complaint: \_\_\_\_\_

2. When did you last visit a dentist? \_\_\_\_\_ Name of Dentist?\_\_\_\_\_

What treatment was performed:\_\_\_\_\_

3. When was your last full set of X- rays taken? \_\_\_\_\_

Would you like us to request recent x-rays? Yes\_\_\_\_\_ No\_\_\_\_\_

4. Have you ever had prolonged bleeding after an extraction? Yes\_\_\_\_\_ No\_\_\_\_\_

If yes, please explain:\_\_\_\_\_

5. Have you had any problems with past dental treatment? Yes\_\_\_\_\_ No\_\_\_\_\_

If yes, Please specify: \_\_\_\_\_

6. Do you have any problems associated with movement of the lower jaw such as, clicking, popping, pain or locking when open? Yes\_\_\_\_\_ No\_\_\_\_\_

If yes, please specify\_\_\_\_\_

7. Have you ever been diagnosed or treated for TMD (Temporomandibular Joint Dysfunction, sometimes called TMD)? Yes\_\_\_\_\_ No\_\_\_\_\_

If yes, please specify\_\_\_\_\_

8. Do your gums bleed easily? Yes\_\_\_\_\_ No\_\_\_\_\_

9. Do you feel you have bad breath? Yes\_\_\_\_\_ No\_\_\_\_\_

10. Are your teeth sensitive to hot and cold? Yes\_\_\_\_\_ No\_\_\_\_\_

11. Would you like your teeth whiter? Yes\_\_\_\_\_ No\_\_\_\_\_

12. Are there any cosmetic changes you would like to have done? Yes\_\_\_\_\_ No\_\_\_\_\_

If yes, please explain \_\_\_\_\_

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. I further certify that I consent to the performing of X-rays and oral examination.

\_\_\_\_\_  
Signature of Patient / Parent

\_\_\_\_\_  
Date