Dental Health History

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SUMMIT VIEW
BIOLOGICAL DENTISTRY & WELLNESS
SCOTT M. CHANDLER, DMD
MATTHEW D. GEDDES, DDS

Dental Health History

Date of last Dental Exam?

MM/dd/yyyy

Are you having any dental discomfort at this time? *

Yes No

Do you feel nervous about having dental treatment? *

Yes No

Are your teeth sensitive to hot or cold or sweets? *

Yes No

Are you interested in Whitening your smile? *

Yes No

How often do you brush your teeth?

Floss?

Do your gums bleed while brushing or flossing? *

Yes No

Do you get frequent fever blisters, mouth ulcers or sores on your lips or in your mouth? *

Yes No

Have you ever had burning of the tongue or cracking of the corners of your mouth? *

Yes No

Do you chew/smoke tobacco in any form? *

Yes No

Have you had any head, neck or jaw injuries? *

Yes No

Do you notice popping, clicking, or soreness of the jaws or point just in front of the ears? *

Yes No

Do you clench or grind your teeth? *

Yes No

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Have you ever had orthodontic treatment? *

Yes No

Do you wear dentures or partials? *

Yes No

Are you happy with your dentures? *

Yes No NA

Do you have problems with your teeth or fillings breaking? *

Yes No

Do you have, or have you ever been told you have Pyorrhea (Periodontal Disease)? *

Yes No

Do you have difficulty opening your mouth widely? *

Yes No

Do you have an unpleasant taste or odor in your teeth/mouth? *

Yes No

Does food catch between your teeth? *

Yes No

Are you happy with your smile? *

Yes No

Would you like to change anything about your smile?

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 patients) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian *

Date

10/08/2024