Prosthodontics
OF NEW YORK

DENTAL HISTORY

PATIENT NAME _____
LAST FIRST MIDDLE

REASON FOR TODAY'S VISIT: _____

DESCRIBE YOUR DENTAL PROBLEMS: _____

_____

HOW LONG SINCE YOUR LAST DENTAL VISIT? _____

WHEN WAS THE LAST TIME YOUR TEETH WERE CLEANED? _____

HOW LONG SINCE YOUR LAST DENTAL X-RAYS? _____

PREVIOUS DENTIST'S NAME: _____

ADDRESS/PHONE # _____

PLEASE CIRCLE IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

TOOTH SENSITIVITY	BLEEDING GUMS
YELLOW TEETH	BROKEN FILLINGS
MISSING TEETH	BAD BREATH
GRINDING/CLENCHING	CHIPPED/BROKEN TEETH
FOOD COLLECTION	SORE GUMS
LOOSE TEETH	JAW CLICKING OR POPPING
HEADACHES	JAW DISCOMFORT
FACIAL TRAUMA	ORAL SURGERY
ORAL CANCER	RADIATION THERAPY
DRY MOUTH	RECURRENT CANKER SORES
ORTHODONTICS/BRACES	PERIODONTAL TREATMENT
ROOT CANAL THERAPY	CROWN & BRIDGE
DENTURES	IMPLANT THERAPY
TOOTH WHITENING	ESTHETIC DENTISTRY

OTHER DENTAL ISSUES NOT CIRCLED ABOVE: _____

DO YOU LIKE THE APPEARANCE OF YOUR TEETH? YES NO

IF NO, WHY? _____

IF THERE WAS SOMETHING YOU COULD CHANGE ABOUT YOUR SMILE, WHAT WOULD IT BE? _____

WOULD YOU LIKE A WHITER, HEALTHIER SMILE? _____

SIGNATURE: _____ DATE: _____

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