**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: _____

**Jonathan Roberts, DDS & Craig Sirota DMD, MMSC**
18 East 48th Street • Suite 1501 • New York, NY 10017 • T: 212.758.9690