DENTAL HISTORY

CRE INC.

Referred by _____

Previous dentist _____ How long _____

Last dental exam _____ Last dental x-ray _____

Last dental treatment _____

How often do you have your teeth cleaned? 3 mo _____ 4 mo _____ 6 mo _____ 1 yr or longer _____

WHAT IS YOUR IMMEDIATE DENTAL CONCERN? _____

_____

PLEASE CHECK IF YOU HAVE, OR EVER HAD THE FOLLOWING:

1. unhappy with appearance of your teeth ❑
2. unfavorable dental experiences ❑
3. dental fears ❑
4. preference for no dental anesthetic ❑
5. problems with effectiveness or bad reactions to dental anesthetic ❑
6. orthodontic treatment (braces) when ❑
7. periodontal (gum) treatment when ❑
8. bleeding gums ❑
9. avoid brushing any part of your mouth ❑
10. part of your mouth is sensitive to temperature ❑
11. sore teeth ❑
12. a burning sensation in your mouth ❑
13. difficulty swallowing ❑
14. an unpleasant taste or odor in your mouth ❑
15. jaw problems (temporomandibular joint) ❑
16. difficulty opening your mouth widely ❑
17. stiff neck muscles ❑
18. awaken with an awareness of your teeth or jaws ❑
19. tension headaches ❑
20. clench or grind your teeth ❑
21. jaw clicking or popping ❑
22. lost any teeth ❑

SUPPLEMENTAL DENTURE HISTORY:

If you are wearing a partial or complete artificial denture, please complete the following:
YES NO (Please check Yes or No)

❑ ❑ Has your present denture been relined? When? _____
❑ ❑ Is your present denture a problem? Describe _____
❑ ❑ Satisfied with the appearance? _____
❑ ❑ Satisfied with the comfort? _____
❑ ❑ Satisfied with the chewing ability? _____
When did you receive your first partial or complete denture? _____
How long have you worn your present denture? _____

Patient's Signature _____ Date _____

Dentist's Remarks: _____

_____ Rev: _____

OVER