DENTISTRY AT
HICKORY FLAT

Dental History

Welcome! We are so glad that you are here. Please complete this dental history form so that we may provide you with the best possible care. All information is kept confidential.

Date:_____ Name:_____

Reason for your visit today?_____

_____

_____

Approximate Date of:

Last Dental Exam: _____ Last Cleaning:_____ Full Set of X-rays: _____

Dental Anxiety Level: ☐Low ☐Normal ☐High

What kind tooth brush do you use? ☐Manual ☐Electric What type? ☐Soft ☐Medium

Do you use any other dental aids? (check all that apply) ☐Waterpik ☐Toothpicks ☐Fluoride rinse

☐Mouth Wash ☐Other_____

How often do you brush?_____ How often do you floss?_____

Are any of your teeth sensitive to: (check all that apply) ☐Hot ☐ Cold ☐Sweets ☐Chewing /Pressure

Have you ever had *(check all that apply):*

- ☐ Orthodontic treatment/Braces
- ☐ Endodontic treatment/Root Canal
- ☐ Extractions/Oral Surgery
- ☐ Gum Surgery
- ☐ Biting Lips or Cheeks
- ☐ Scaling and root planning/Deep Cleaning
- ☐ Cold Sore/Fever Blister
- ☐ Frequent Canker Sores
- ☐ Smoking
- ☐ Chewing Tobacco Use
- ☐ Occlusal or Bite adjustment
- ☐ Teeth Whitening/Bleaching
- ☐ Clicking or Popping of the Jaw
- ☐ Pain in Ear, Jaw or Face
- ☐ Difficulty Opening or closing mouth
- ☐ Frequent Headaches
- ☐ Excessive Stress

Check any that apply to you:

- ☐ Bleeding or Painful Gums
- ☐ Bad taste in your mouth
- ☐ Loose Teeth
- ☐ Wearing Night guard
- ☐ Food catching between your Teeth
- ☐ Clench/grind teeth

Signature: _____ Date:_____

(Patient/Parent or Guardian)