DENTAL HISTORY

PATENT NUMBER _____

Dr. Jean F. Reitter
1809 Verdugo Blvd. #207
Glendale, CA 91208
(818) 790-4567

Patient's Name : Last _____ **First** _____ **Inital** _____ **Date of Birth** _____

1. Purpose of Initial Visit _____

2. Are you aware of a problem? _____

3. How long since your last dental visit? _____

4. What was done at that time? _____

5. Previous dentist's name _____

6. When was the last time your teeth were cleaned? _____

CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER. PLEASE WRITE DON'T KNOW ON THE LINE AFTER THE QUESTION.

7. Have you made regular visits? ---------- **Yes** _____ **No** _____

How often: _____

8. Were dental X-Ray Taken? ---------- **Yes** _____ **No** _____

9. Have you lost any teeth or have any teeth been removed? ---------- **Yes** _____ **No** _____

10. Have they been replaced? ----------

a. Fixed Bridge _____ **Age** _____

b. removable bridge _____ **Age** _____

c. denture _____ **Age** _____

d. Implant _____ **Age** _____

12. Are you unhappy with the replacement? ---------- **Yes** _____ **No** _____

12. Would you like to know about permanent replacements? ---------- **Yes** _____ **No** _____

14. Have you ever had any problems or complications with previous dental treatment.

Yes _____ **No** _____

15. Do you clench or grind your teeth? ---------- **Yes** _____ **No** _____

16. Does your jaw click or pop? ---------- **Yes** _____ **No** _____

17. Have you experienced any pain or soreness in the muscles or your face or around your ear? ---------- **Yes** _____ **No** _____

18. Do you have frequent headaches, neckaches or shoulder aches? ---------- **Yes** _____ **No** _____

19. Does food get caught in your teeth?---------- ---------- **Yes** _____ **No** _____

20.Are any of your teeth sensitive to: Hot? _____ **Cold?** ____ **Sweets?** _____ **Pressure?** _____

21. Do you gums bleed or hurt? ---------- **Yes** _____ **No** _____

22. How often do you brush your teeth?_____ **When?** _____

23. Do you use dental Floss? Yes _____ **No** _____ **How often?** _____

24. Are any of your teeth loose, tipped, shifted or chipped?---------- **Yes** _____ **No** _____

25. Are you unhappy with the appearance of your teeth? ---------- **Yes** _____ **No** _____

26. Do you feel your breath is offensive at times? ---------- **Yes** _____ **No** _____

27. Have you ever had gum treatment or surgery? ---------- **Yes** _____ **No** _____

28. Have you had any orthodontic work? ---------- **Yes** _____ **No** _____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

Patients/ Guardian's signature _____ **Date** _____