DENTAL HISTORY

Name of Patient: ____________________

Date of last visit: __________________

What was done:___________________________________

Date of last cleaning: _________________

Purpose of today's visit:

____

	Y	N
Do you like your smile?	☐	☐
Are you happy with the color of your teeth?	☐	☐

If you could change anything about your smile what would it be? explain:____________________________

____

	Y	N
Are you happy with the function of your teeth?	☐	☐
Is it important for you to keep your teeth?	☐	☐
Do you have dental pain?	☐	☐

Any of your teeth sensitive to : ☐ HOT ☐ COLD ☐ SWEET ☐PRESSURE

	Y	N
Any broken teeth or fillings?	☐	☐

SLEEP	Y	N
Do you snore?	☐	☐
Did someone tell you that you snore?	☐	☐
Have you suddenly awakened gasping for breath while sleeping?	☐	☐
Have you had you sleep evaluated/ sleep test?	☐	☐
Do you own a CPAP?	☐	☐
How often do you use your CPAP?	☐	☐
Are you happy with your CPAP?	☐	☐
Are you jaws tired when you wake up?	☐	☐

GUM	Y	N
Does your gum bleed?	☐	☐
Does your gum hurt?	☐	☐
Bad taste or odor?	☐	☐

How often do you brush? ________ When _______________

How often do you floss? __________ When _______________

	Y	N
Have you ever had gum surgery?	☐	☐
Have you notice loosening of your teeth?	☐	☐

TMJ	Y	N
Have you been treated for TMJ or TMD problem?	☐	☐
Any injury to face, head, and neck ?	☐	☐
Clicking/ popping jaw?	☐	☐
Pain of jaw joint, ear, side of face?	☐	☐
Soreness of muscles of the jaw?	☐	☐
Difficulty in opening/ closing ?	☐	☐
Difficulty in chewing?	☐	☐
Do you clench/ grind your teeth?	☐	☐
Are your jaws tired especially in the morning?	☐	☐
Did you have braces?	☐	☐
Did you have unpleased experience at the dentist?	☐	☐
Do you have question and concerns?	☐	☐

Please mark any services you would like to further discuss with Dr. Onimisi:

- ☐ Snoring
- ☐ Braces
- ☐ Clear Correct
- ☐ Invisalign
- ☐ Implants
- ☐ In Office Oral Sedation
- ☐ Retainer Making
- ☐ Oral Cancer Screening
- ☐Teeth Whitening (Bleaching)
- ☐ Dentures
- ☐ Bonding
- ☐ Inlays/ Onlays
- ☐ Snap on Smile
- ☐ Bridges/ Partials
- ☐ Mouth Guards
- ☐ Teeth Grinding/ TMJ/ TMD
- ☐ Deep Gum Cleaning
- ☐ Wisdom Teeth Extractions
- ☐ Tooth Colored Crowns
- ☐ Porcelain Crowns
- ☐ Tooth Colored Fillings
- ☐Gum Contouring
- ☐ Root Canal Treatment
- ☐ Extractions
- ☐ Sealants
- ☐ Veneers
- ☐ Lumineers
- ☐ Metal Free Denture

Dental History Acknowledgement

I understand that the information in the Dental History I have given is correct and to the best of my knowledge. I also understand that this information will be held in the strictest of confidence, and that you have my permission to ask the respective health care provider or agency for further information if needed. It is my responsibility to inform this office of any changes in my health or medications.

Signature: _______________________ Relationship to patient: ______________________ Date: ____________

Doctor Signature: ____________________________________ Date: __________________