ROMAS FAMILY DENTAL

1155 Parkway Drive, Suite 100
Zionsville, IN 46077
317-733-1965

DENTAL HEALTH HISTORY

Patient's name_____ Today's Date_____

Date of last dental visit_____ Name of previous dentist_____

Address of previous dentist_____City_____State_____Phone#_____

How often do you go to the dentist?_____How often do you have your teeth cleaned?_____

Have you ever had professional instructions on home care? ☐ Yes ☐ No

Are you having any discomfort at this time? ☐ Yes ☐ No

If yes, describe discomfort._____

Have you ever had any serious trouble associated with previous dental treatment? ☐ Yes ☐ No

If yes, please explain._____

Does dental treatment make you nervous? ☐ Yes ☐ No
Please mark. ☐ Slightly ☐ Moderately ☐Extremely

Have you ever been treated for periodontal disease (gum disease)? ☐ Yes ☐ No

If yes, when? _____

Have you ever had any teeth removed? ☐ Yes ☐ No How long ago? _____

Were they replaced? ☐ Yes ☐ No Was it ever suggested? ☐ Yes ☐ No

Do you know extensive destruction of the bone under the gum can take place before you are aware of it?
☐ Yes ☐ No

How often do you brush? Do you brush lightly or vigorously?

How often do you floss? Do you brush your tongue? ☐ Yes ☐ No

Do you have or are you concerned with any of the following? If yes, please mark the box.

☐ Bleeding or sore gums	☐ Biting your cheeks or lips	☐ Loose teeth
☐ Unpleasant or bad breath	☐ Clicking or popping your jaw	☐ Teeth sensitive to hot or cold
☐ Burning tongue or lips	☐ Difficulty opening or closing	☐ Teeth sensitive to sweets
☐ Swelling or lumps in mouth	☐ Orthodontia (Braces)	☐ Teeth sensitive to chewing
☐ Blister(s) in mouth or on lips	☐ Ringing or pain in ears	☐ Clenching or grinding
☐ Food packing between teeth	☐ Shifting or change in bite	☐ Bite fingernails/hard objects
☐ Other: _____		

Are you pleased with the appearance of your teeth? ☐ Yes ☐ No
If not, what would you like to change?_____

_____

What is your main concern?_____

_____