SKYLINE DENTAL

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Dental History

Patient Name: _____ _____ ____ _____
Last First MI Preferred Name

Reason for your visit to our office?

_____

_____

Have you ever had a serious problem associated with previous dental treatment? ☐ **Yes** ☐ **No**

If yes, please explain:

_____

_____

How often do you brush your teeth? _____

What Dental aids do you use?

☐ **Floss** ☐ **Water Pik** ☐ **Tooth Pik** ☐ **Electric/Sonicare Toothbrush** ☐ **Perio Aid** ☐ **Other**

Are you familiar with the term "Preventative Dentistry"? ☐ **Yes** ☐ **No**

When used properly, do you believe in the dental benefits of Fluoride? ☐ **Yes** ☐ **No**

Do you Plan on maintaining your teeth for the rest of your life? ☐ **Yes** ☐ **No**

Please select an of the following that which apply to you:

- ☐ **Gums Bleed during brushing or flossing**
- ☐ **Pain with brushing or flossing**
- ☐ **Usually break filings or teeth**
- ☐ **Jaws frequently feel tired or sore**
- ☐ **Bad odors or tastes in mouth**
- ☐ **Currently (or previously) use a mouth guard or splint**
- ☐ **Food frequently gets caught between teeth**
- ☐ **Previous (or current) Orthodontics (braces)**
- ☐ **Currently unhappy with the appearance or color of your teeth or smile**
- ☐ **Currently using a Tartar Control, Whitening or Baking soda Toothpaste**
- ☐ **Gums tender or swollen**
- ☐ **Frequent sensitivity to cold, hot or sweets**
- ☐ **Pain with biting or chewing**
- ☐ **Regularly clench or grind your teeth**
- ☐ **Apprehensive or nervous about dental work**
- ☐ **Frequent cold sores, blisters or other oral/lip lesions**
- ☐ **Previous (or current) Periodontal (gum) surgery**
- ☐ **Previous (or current) Periodontal (gum) surgery**
- ☐ **Either took fluoride as a child, or grew up in a fluoridated community**
- ☐ **None of the listed dental conditions apply**