CASTOR FAMILY DENTISTRY

DENTAL HISTORY

_____

Full Name

Purpose of your visit today: _____
_____
_____

Are you receiving routine dental care? Y N

Date of last dental visit: _____

Name of previous dentist: _____

Have any of the following prevented you from seeking dental care?

___ Fear or anxiety
___ Lack of time
___ Lack of funds/ cost
___ No insurance
___ Other: _____

Have you ever had problems/ complications with past dental care? Y N

If yes, describe: _____
_____

Did you drink fluoridated water as a child (age 1-12)? Y N

What is your current primary water source?

_____ City _____ Well _____ Bottle

HYGIENE PRACTICES

Tooth Brush: _____ Electric _____ Manual
_____ Soft _____ Medium _____ Hard

Brush: _____ # times per day
Floss: _____ # times per day
Rinse: _____ # times per day

Other home care: _____
_____
_____

Do you use bleaching products? Y N

Describe: _____
_____

DENTURES/ PARTIALS

How long have you worn them? _____

Any current problems? _____
_____

Indicate any past dental treatment:

_____ Orthodontics (braces)
_____ Oral surgery (extractions, biopsy)
_____ Periodontics (gum treatment or surgery)

Are your teeth sensitive to:

_____ Sweets
_____ Hot
_____ Cold
_____ Pressure (chewing/ biting)
_____ Other

Do you have any swelling(s) in your mouth? Y N
Are your teeth shifting? Y N
Are your teeth loose? Y N

SALIVARY FUNCTION

Does your saliva feel thick? Y N
Does your mouth often feel dry? Y N
Do you have difficulty chewing food? Y N
Do you have difficulty swallowing? Y N
Do you have difficulty speaking? Y N
Do you have excess saliva? Y N

TMJ/ JAW PROBLEMS

Clicking/Popping jaws? Y N
Pain? Y N
Locked open or closed? Y N

OTHER CONCERNS: _____
_____
_____
_____
_____
_____

SMILE EVALUATION

1. Are you satisfied with the appearance of your teeth? Y N
   _____
2. Are your teeth straight? Y N
   _____
3. Do you like the color of your teeth? Y N
   _____
4. Are there old fillings or other dental work that you don't like the look of? Y N
   _____