Elizabeth V. Wawrzewski, DDS

New Patient Dental History Form

What is the reason for your visit? ____

When was your last dental visit? ____

What treatment was done at your last dental visit? ______________________________________

How often did you visit the dentist before then? ____

Previous Dentist: ____

Have you had a complete series of xrays taken? ◯ Yes ◯ No If yes, When/ Where? ______________

How often do you brush your teeth? ____

How often do you floss your teeth? ____

Do your gums bleed while flossing? ◯ Yes ◯ No

Do you feel pain in any teeth? ◯ Yes ◯ No

Are your teeth sensitive to liquid or foods? ◯ Yes ◯ No

Are your teeth sensitive to hot or cold? ◯ Yes ◯ No

Are your teeth sensitive to sweet or sour? ◯ Yes ◯ No

Are your teeth sensitive to pressure? ◯ Yes ◯ No

Does food get caught in your teeth? ◯ Yes ◯ No

Do you clench or grind your teeth? ◯ Yes ◯ No

Do you bite your lips or cheeks? ◯ Yes ◯ No

Do you have any sores or lumps in or around your mouth? ◯ Yes ◯ No

Have you noticed loosening of your teeth? ◯ Yes ◯ No

Have you had any head, neck or jaw injuries? ◯ Yes ◯ No

Have you ever had periodontal (gums) treatment? ◯ Yes ◯ No

Have you had any difficult extractions? ◯ Yes ◯ No

Have you ever worn a bite plate or appliance? ◯ Yes ◯ No

Do you wear dentures or partials? ◯ Yes ◯ No If yes, when was the date of placement? __________

Have you experienced any of the following in your jaw:

◯ Clicking ◯ Difficult opening or closing ◯ Difficulty in chewing ◯ Pain in joint, ear or side of face

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