Time 12:14 PM | Vin Vu, D.D.S. | Date 1/26/2016

Dental History (Copy)

Patient Name: | Birth Date: | Date Created:

Purpose of your visit / Are you having any issues?

How often do you brush your teeth

How often do you floss?

Have you had any of the following:

Fixed Bridge	Yes No	Implants	Yes No	Gum Surgery	Yes No
Dry Mouth	Yes No	Widom Teeth Removed	Yes No	Gum Bleed	Yes No
Braces	Yes No				

Are your teeth sensitive to:

Hot	Yes No	Cold	Yes No
Sweets	Yes No	Pressure	Yes No

Have you ever been diagnosed with a problem with either jaw joint?	Yes No	If yes
Does your jaw click, pop, or make noise when you open or close?	Yes No	If yes
Do you have tenderness in your jaw when you open, close or chew?	Yes No	If yes
Has your jaw ever locked open or closed?	Yes No	If yes
Do you have frequent headaches? If so how often and when?	Yes No	If yes
Do you have a history of trauma to your jaw?	Yes No	If yes
Do you clench or grind your teeth, or been told that you do?	Yes No	If yes

Have you ever had any problem, unpleasant experiences, or complications with previous dental treatment?

How do you feel in general about your teeth? Are there any areas you are unhappy with?

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

Signature of Patient, Parent or Guardian:

X Date:_____