Victoria Dental Centre
Family & Cosmetic Dentistry

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#339 Wellington Rd, Unit 105 Medcen
London, ON N6C 5Z9

Dental History

MEDIC ALERT	ALLERGIES	MEDICATIONS	HEALTH CONDITION	PHYSICAL

DENTAL HISTORY for _____ month / day / year

1. Reason for today's visit: ☐ Exam ☐ Cleaning ☐ Emergency ☐ Other _____

Is there a central problem you would like to have taken care of as soon as possible? _____

2. How frequently do you see your dentist? ☐ 6 Months ☐ Yearly ☐ Other _____

Former dentist _____ Last dentist visit _____

Last cleaning _____ Last full mouth series of x-rays _____ X-rays requested _____

3. Have you been given oral hygiene instruction in: ☐ Brushing ☐ Flossing ☐ Other _____ By whom? _____

4. Brushing: ☐ Vigorous ☐ Light How often? _____ Type of brush? _____

5. How often do you floss your teeth? _____

6. Other cleaning aids used: ☐ Floss ☐ Stimudents ☐ Toothpick ☐ Other _____

7. Are any of your teeth sensitive to: ☐ Cold ☐ Sweets ☐ Heat ☐ Other _____

8. Do your gums bleed when: ☐ Brushing ☐ Flossing ☐ Spontaneously

9. Is your sugar intake: ☐ High ☐ Medium ☐ Low

10. Have you ever had or do you now have any of the following?

- ☐ Bridges
- ☐ Partial dentures
- ☐ Full dentures
- ☐ Root canal fillings
- ☐ Dental implants
- ☐ Lost fillings
- ☐ Extractions
- ☐ Loose teeth
- ☐ Orthodontic treatment
- ☐ Bite adjustment
- ☐ Bite appliance/night guard
- ☐ Swelling or pain in your mouth or jaws
- ☐ Injuries to your face or jaws
- ☐ Surgery in your mouth
- ☐ Gum treatments
- ☐ Gag easily
- ☐ Difficulty opening or closing your jaw

	Yes	Don't know/ Maybe	No
11. Do you chew on only one side of your mouth? If so, why? _____	☐	☐	☐
12. Does any part of your mouth hurt when clenched? _____	☐	☐	☐
13. Does your jaw crack or pop when opened widely? _____	☐	☐	☐
14. Do you have any pain in your ears? _____	☐	☐	☐
15. Have you experienced any growth or sore spots in your mouth? If so, where? _____	☐	☐	☐
16. Do you: - grind or clench your teeth during the day or night? _____	☐	☐	☐
- mouth breathe while awake or asleep? _____	☐	☐	☐
- bite your lips or cheecks regularly? _____	☐	☐	☐
- hold any foreign objects with your teeth? (i.e. pipe, pencils, nails) _____	☐	☐	☐
- smoke? ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Other _____ No. per day _____	☐	☐	☐

17. Check any of the following you are interested in or you have thought about:

- ☐ Orthodontics (braces)
- ☐ Bonding (straightening)
- ☐ Closing spaces between teeth
- ☐ Repairing chipped teeth
- ☐ Bleaching (whitening teeth)
- ☐ Crowns (caps)
- ☐ Improved gum health
- ☐ Improving your bite
- ☐ Improving breath odor
- ☐ Replacing missing teeth
- ☐ Sports mouth guard
- ☐ Improving your smile

18. Would you rate your current dental health as: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

19. Do you have any emotional concerns regarding your dental visit? ☐ Fear ☐ Pain ☐ Time ☐ Money ☐ Embarrassment

☐ Other concerns _____

Comments _____

INFORMED CONSENT / GENERAL RELEASE

I, the undersigned, state that I have provided an accurate and complete Medical/Dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers regarding this Medical/Dental history and I consent to my physician being contacted if necessary. I authorize the dentist to perform diagnostic, dental and oral surgery procedures and services including the use of anaesthetic as my be necessary. I also understand that I assume responsibility for any and all fees associated with these procedures and services provided to me or my dependents.

Patient / Guardian* Signature _____ Date _____ / _____ / _____ month / day / year

If parent, guardian, please print name _____

*Guardian of Child or Guardian of Adult under Guardianship