**Lasting Impressions Dentistry** | **CONFIDENTIAL Dental History** | **David Loshin, DMD, PLLC**

Name ______ Age ______ Today's date ______ Approx. date of most recent dental exam ______

Name of former dentist ______ Phone ______ Address or location of clinic ______

**What is your estimate of your general dental health?** ☐ Excellent ☐ Good ☐ Fair ☐ Poor

**If you desire LIMITED treatment today for a specific urgent problem please check here** ☐

**If you desire a COMPLETE DENTAL EVALUATION please check here** ☐

If you are currently having any dental pain or discomfort please describe here:

If there is a dental problem that is not painful but of immediate concern, please describe here:

# Teeth

- If you usually have a lot of cavities, check here ☐
- How long ago did you have your last cavity (How many years) ?
- If you have any missing teeth how many years ago were they removed:
- If you wear any removable bridges or dentures or partials how many years ago were they placed:
- If they do NOT function satisfactorily check here ☐ If they are NOT satisfactory cosmetically check here ☐
- Are you aware of any holes, pitting, craters, discolorations or other problems on the surface of your teeth ? ☐
- Have you ever broken or chipped any teeth ? ☐
- Have you ever had any traumatic accidents involving your teeth ? ☐
- Have you had your wisdom teeth removed ? ☐
- Are you aware of any grooves or notches on your teeth near the gumline ? ☐
- Do you chronically get food caught between certain teeth or have excess space between teeth that bothers you ? ☐
- Are any of your teeth overly sensitive to cold? ☐ To sweets ☐ To chewing pressure ☐ Impossible to floss ? ☐

# Gums

- Do your gums bleed when brushing or flossing ? ☐
- Have you ever had a “deep cleaning” or other treatment for gum disease ? ☐
- Have you ever had any mouth surgery other than wisdom teeth removal ? ☐
- Are you aware of any unpleasant taste or odor in your mouth or chronic bad breath ? ☐
- Do any immediate family members have chronic periodontal disease or generally bad gums and breath ? ☐
- Are you aware of any loose teeth? ☐ Gum recession? ☐ Prior gum graft? ☐

# Etc.

- Do you have any problems chewing hard foods ? ☐
- Do you ever grit, grind or clench your teeth at night? ☐ During the day ? ☐
- Have you ever received treatment for jaw joint (TMJ), or bruxism problems? eg. nightime appliance ? ☐
- Have you ever had orthodontic treatment (braces), or tooth movement appliances such as Invisalign ? ☐
- Are you fearful of dental treatment? ☐ Do you often have problems getting numb for dental treatment ? ☐
- Have you ever felt uncomfortable or self conscious about the appearance of your teeth or smile? ☐
- Is there anything you would like to be different about the appearance of your teeth or smile ? ☐
- Have you ever had your teeth whitened professionally in a dental office procedure using a special light ? ☐
- Using custom trays at home? ☐ Using over the counter products? ☐
- Do you desire to keep your natural teeth for your entire life ? ☐
- I brush ______ times / day. I floss ______ times / week. I mostly use a manual brush? ☐ Mostly an electric? ☐

**I affirm that the information given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my dental status at future dental visits.**

Signature ______ Date ______