NORTHSIDE DENTAL CENTER, PA

DENTAL HISTORY

Patient Name: _____ DOB: _____

Previous Dentist: _____ Date of last visit: _____

When was the last time you had X-Rays done? _____

Please circle Yes or NO

Are you having any dental problems?	YES	NO
Do your gums bleed when you brush or floss?	YES	NO
Has gum treatment ever been recommended to you?	YES	NO
Have you or a family member ever been treated for periodontal disease?	YES	NO
Have you ever had an oral cancer screening?	YES	NO
Are any of your teeth sensitive to hot or cold?	YES	NO
Do you grind your teeth at night?	YES	NO
Have you ever had any TMJ treatment?	YES	NO
Have you ever had complications from an extraction?	YES	NO
Do you use Tobacco, Smoke, or Vape:	YES	NO
Have you ever had orthodontic treatment?	YES	NO
Have you ever had a reaction to a crown, metal filling, or dental appliance?	YES	NO

I certify that I have read and understand the questions above. I acknowledge that these questions have been answered to my satisfaction. I will not hold my dentist or any other members of his staff responsible for any errors that I have made in the completion of this form.

Patient Signature: _____ Date: _____

Parent/Guardian (if patient is a minor): _____ Date: _____