



Dental History

Platinum Dental Care
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Name _____ Date _____
First Mi. Last

Reason for Today's Visit _____

Date of last exam _____ Date of last dental X-rays _____

How often do you brush? _____

What type of toothbrush do you use? regular electric

How often do you floss? _____

Do you use mouthwash or some other type of rinse? Yes No Describe _____

Do you have any dental problems now? Yes No Describe _____

Have you ever had an upsetting dental experience? Yes No Describe _____

Have you ever had: Orthodontics Periodontal Surgery Oral Surgery

Please check any of the following conditions that apply to you:

- Bad Breath
- Grinding Teeth
- Sensitivity to Hot
- Bleeding Gums
- Loose Teeth or Broken Filling
- Sensitivity to Cold
- Clicking or Popping jaw
- Periodontal Treatment
- Sensitivity When Biting
- Food Collection between Teeth
- Sores or Growths in Your Mouth
- Sensitivity to Sweets
- Tired jaws in the morning
- Sore Facial Muscles
- Wear a Night Guard
- Difficulty in opening or closing the mouth
- Headaches or Neck Aches

Other: _____

Previous Dentist's Name _____

Office Address _____

City _____ State _____ Zip _____

Telephone (_____) _____