HARBOR SQUARE DENTAL
Nicole Serra, DDS & Amy Winter, DDS
(425) 778-7477

DENTAL HISTORY

Patients Name: _____Date of Birth_____
Previous Dentist (name & location) _____
Date of Last visit _____Date of last dental x-rays _____
What was done at your last dental visit? _____
How often were you getting your teeth cleaned? _____
Are you in pain today? **YES** **NO** Location_____

FOR DENTAL PATIENTS OVER THE AGE OF 7

DENTAL SYMPTOMS: please check if you have of the following:

- ◊ Chew on one side of mouth
- ◊ Cracked or broken teeth/fillings
- ◊ Sensitivity when biting
- ◊ Sensitivity to hot
- ◊ Sensitivity to cold
- ◊ Sensitivity to sweets
- ◊ Sensitivity when brushing
- ◊ Unhappy with the appearance of your teeth

PERIODONTAL SYMPTOMS: please check if you have any of the following:

- ◊ Bleeding gums with brushing and/or flossing
- ◊ Swollen or tender gums
- ◊ Loose teeth
- ◊ Tartar build-up (calculus deposits)
- ◊ Bad Breath
- ◊ Food collection between teeth
- ◊ Diagnosis of gum disease (periodontal disease)
- ◊ Deep cleanings at a previous dental office

How often do you brush? _____
How often do you floss? _____
How would you rate your current dental health?
Poor **Fair** **Good** **Excellent**
What type of tooth brush do you currently use?
Manual **Electric**
What type of bristles? **Soft** **Med** **Hard**

HABITS: please check if you do any of the following

- ◊ Smoke cigarettes, pipes or cigars
- ◊ Use smokeless tobacco
- ◊ Bite fingernails
- ◊ Chew Ice
- ◊ Drink more than 12 ounces of soda, juice sports drinks or flavored coffee each day

TMJ: (Temporomandibular Joint): please check if you have any of the following:

- ◊ Chew on one side of mouth
- ◊ Cracked or broken teeth/fillings
- ◊ Sensitivity when biting
- ◊ Sensitivity to hot
- ◊ Sensitivity to cold
- ◊ Sensitivity to sweets
- ◊ Sensitivity when brushing
- ◊ Unhappy with the appearance of your teeth

OTHER: Please write down any other dental history we should be aware of, including surgeries or negative dental experiences

_____
_____
_____
_____
_____
_____
_____

PATIENTS UNDER 7 YEARS OF AGE

Has your child been to the dentist before?	**YES**	**NO**
Has your child had dental x-rays?	**YES**	**NO**
How often does your child brush and floss their teeth?	**YES**	**NO**
Does your child receive help brushing and flossing?	**YES**	**NO**
Does your child have a source of fluoride other than toothpaste?	**YES**	**NO**
Please describe:_____		
Does your child get a bottle or nurse at night?	**YES**	**NO**
Does your child have any habits such as thumb sucking or pacifier?	**YES**	**NO**
Please describe: _____		
Have you or your spouse had any serious dental problems?	**YES**	**NO**

Please describe anything else about your child you feel we should know:_____
_____Dr. Initials_____Date_____