SCHIMP
FAMILY DENTISTRY

PATIENT DENTAL HISTORY

Ages 14 +

Name: _____ Age: _____

Former Dentist: _____

Reason for today's visit:

_____

_____

Date of last exam: _____Date of last dental xray:

_____

How often do you brush: _____How often do you floss:

_____

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

___Bad breath

___Bleeding gums

___Clicking or popping jaw

___Food collection between teeth

___Grinding teeth

___Loose teeth or broken fillings

___Periodontal treatment

___Sensitivity to cold

___Sensitivity to hot

___Sensitivity to sweets

___Sensitivity when biting

___Sores or growths in your mouth

Anything else about your dental history you feel we should know about: