Olney Dental

W e l l n e s s

The Art & Science of Dentistry
Neal F. Hoyson, D.M.D.

Patient Dental History

When was your last dental appointment?_____

Are you satisfied with the appearance of your teeth? _____

If not, what would you like changed? _____

Do you have any sensitive teeth?_____ If yes, where? _____

Do you have any loose teeth? _____ If yes, where? _____

Have you noticed any swelling, lumps or sores in your mouth? _____ If yes, where? _____

Do you have difficulty chewing your food? _____ If yes, where? _____

Do you have any areas which break floss of where food lodges? _____ If yes, where? _____

Have you had a toothache recently? _____ If yes, where? _____

Do your gums bleed when you brush / floss? _____

Have you had orthodontic treatment (Braces)? _____

Have you had periodontal (Gum) treatment? _____

Do you grind, clench or grit your teeth? _____

Are you aware of any clicking or popping in either TMJ (jaw joint)? _____

Do you experience any discomfort in either TMJ (jaw joint)? _____

What type of toothbrush are you now using (soft, medium, hard)? _____

Do you use dental floss? _____ If so, how often? _____

When did you last receive instruction on proper cleansing of your teeth? _____

Please list any dental concerns that you would like to bring to our immediate attention: _____
_____

Have you had any serious trouble associated with previous dental treatment? _____
_____

What is the reaction to having dental treatment?   Dread it ❑   Worry about it ❑   Don't mind it ❑

I certify that the answers given are correct to the best of my knowledge. Furthermore, I understand that even though I have some type of insurance coverage, I am financially responsible for services rendered. I hereby authorize release of any information regarding my insurance claims to my insurance company.

_____   _____

Signature (Parent or Guardian, if patient is a minor)   *Date*