SHETEK DENTAL CARE **2711 BROADWAY AVE., SLAYTON, MN 56172 PHONE: 507-836-1000**

Patient Dental History Name _____

Name of your previous dentist_____ Date of last exam_____

1.) Do your gums bleed while brushing or flossing?..... **Y** **N**

2.) Do you clench or grind your teeth?..... **Y** **N**

3.) Do you experience pain or clicking in your jaw joints?..... **Y** **N**

4.) Have you had trauma to your jaw?..... **Y** **N**

5.) Do you have frequent headaches?..... **Y** **N**

6.) Do you have any of the following habits? (**Circle**)Mouth breathing, bulimic or anorexic, cigar/cigarette/pipe smoker, smokeless tobacco, bite nails, thumb/finger, chewing gum, sucking on hard candy/cough drops often, soft-drinks – regular or diet, dry mouth, acid reflux.

7.) How often do you brush?_____ How often do you floss? _____

8.) Have you ever been treated for periodontal disease? Y N Date of Surgery: _____

9.) Are your teeth sensitive to hot/cold, biting/chewing, sweets? (**Circle**)…….....**Y** **N**

10.) Have you had orthodontics (braces),bite guard for grinding or athletics, periodontal(gum disease) treatment, oral surgery, serious injury to your mouth or neck? (**Circle**)

11.) Have you had your wisdom teeth removed?..... **Y** **N**

12.) Do you wear dentures or partials? **Y** **N** Placement date of current appliance: _____

13.) Rate your smile: 1 (poor) to 10 (perfect!) _____

14.) If you could change anything about your smile/teeth, what would it be? _____

_____

15.) Do you have pain in any of your teeth?..... **Y** **N**

16.) What is your chief dental concern?_____

17.) What is your water source?(**Circle**)Rural water, City water, Reverse Osmosis, Well, Bottled

18.) Who may we thank for referring you to our office? _____