Drs Korb and Merat

Patient's Name_____
Last First Date

DENTAL HISTORY FORM

Indicate your reason for today's visit:_____
How long since your last teeth cleaning?_____
How long since your last dental exam and x-rays?_____
Former Dentist_____ Phone number_____

Please indicate if you:

☐ Have any teeth sensitive to: ☐ hot ☐ cold ☐ pressure ☐ sweet
☐ Avoid chewing on one side of your mouth
☐ Habitually ☐ clench ☐ grind your teeth ☐ day ☐ night
☐ Have ever had a bad dental experience
☐ Have had a dentist not be able to get your teeth totally numb
☐ Think that you are more apprehensive then the average dental patient
☐ Had had an accident involving jaw, mouth, or tooth injuries
☐ Ever have mouth odor or a bad taste in your mouth
☐ Gag easily
☐ Have bleeding gums when you brush or floss
☐ Have had gum surgery
☐ Have had deep cleanings

☐ Have had your teeth straightened
☐ Have spaces that you do not like
☐ Unhappy with the color of your teeth
☐ Unhappy with the shape of your teeth
☐ Have chipped teeth
☐ Have old fillings or dental work you do not like looking at
How would you like your teeth to look?_____

FOR OFFICE USE ONLY

PHARYNX_____
TONSILS _____
SOFT PALATE _____
HARD PALATE_____
VESTIBULES _____
SKIN_____
LIPS_____
BUCCAL MUCOSA_____
PAROTID GLAND_____
TONGUE_____
FLOOR OF MOUTH_____
LYMPH NODES_____
OCCLUSION class I II III
TMJ clicking trismus deviation RT LF aches: neck head jaw back