

Lakeshore West Dental

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Etobicoke, Ontario, M8W 1M9

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DENTAL HISTORY Please NO or YES to each question. If unsure of a question, please consult with the dentist.

- Is there a dental problem you would like treated immediately? O NO O YES
Date of your last dental visit? _____ Last dental cleaning? _____ Last x-rays? _____
1. Have you been seeing a dentist regularly? O NO O YES
 2. Have you ever had any of the following?
 - a. Periodontal Treatment (treatment of the gums)? O NO O YES
 - b. Orthodontic Treatment(to straighten or realign teeth)? O NO O YES
 - c. A bit plate or any other appliance? O NO O YES
 - d. Your bite adjusted or teeth ground? O NO O YES
 - e. Oral Surgery?(surgery in or about the mouth/jaw joint, or implant surgery in one or both of your jaw joints?) O NO O YES
 - f. If you answered "yes to the last question, who performed the surgery _____ When? _____
 - g. Are you being followed up by a dental specialist? O NO O YES
 3. Are there any growth or sore spots in your mouth? O NO O YES
 4. Do your gums bleed when brushing or eating, do you suffer from pain or swelling of your gums? O NO O YES
 5. Have you noticed any loose teeth, or, have any of your teeth shifted? O NO O YES
 6. Does food catch between your teeth? O NO O YES
 7. Are any of your teeth sensitive to heat, cold, sweets or pressure? O NO O YES
 8. Have you been advised to take antibiotics before a dental appointment? O NO O YES
 9. Do you use dental floss, proxabrush or stimulents? How Often? _____ O NO O YES
 10. How often do you brush your teeth? _____ Do you feel that you have bad breath? O NO O YES
 11. Have you ever experienced any of the following jaw problems:
 - a. Popping/clicking in your jaw joints? O NO O YES
 - b. Pain in your jaw joints, around your ear, or side of your face? O NO O YES
 - c. Difficulty in opening or closing? O NO O YES
 - d. Pain when teeth are clenched? O NO O YES
 - e. Pain or difficulty while chewing? O NO O YES
 12. Do you have any of the following habits? O NO O YES
 - a. Clenching or grinding your teeth while awake or asleep? O NO O YES
 - b. Biting your cheeks or lips? O NO O YES
 - c. Mouth breathing while awake or asleep? O NO O YES
 - d. Placing foreign objects in your mouth (pencils, nails, pipes, pins, fingernails)? O NO O YES
 13. Do you have any emotional concerns about having dental treatment? O NO O YES
 14. Are you unhappy with the appearance of your teeth? O NO O YES
and, what would you like to see changed _____
 15. Have you ever had an upsetting experience in a dental office, or any complications during or following dental treatment, or, do you have any questions or concerns? O NO O YES

I, the undersigned, certify that I have provided an accurate and complete personal and medical – dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical – dental history. **Should there be any change in either my health status or any other information I have provided, I will advise this dental office.** I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary. I have been advised of the privacy policy of the office and that my personal information will be collected, used and disclosed within the guidelines of the policy. I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services.

Patient/parent guardian signature

Print name

Reviewed by treating dentist

Date