DENTAL HEALTH CARE CENTER

appointments@dentalhealthcarecenter.com
1717 EAST 66TH STREET • Richfield, MN 55423 (612)861-7109

Adult Dental History

If you are a new patient to DHCC, when was your last dental office visit? _____

Have you ever been treated for periodontal disease ◯ Yes ◯ No

How often do you brush your teeth on a daily basis?

☐ Morning ☐ Noon ☐ Night

How often do you floss your teeth on a weekly basis?

☐ 1-3 times a week ☐ 4-6 times a week ☐ 7 days a week ☐ Rarely ☐ Never

What type of toothbrush do you use?

☐ Manual ☐ Electric ☐ Water irrigator

Are any of your teeth sensitive to:

☐ Hot ☐ Cold ☐ Chewing ☐ Sweets

Do you have any:

☐ Mouth ulcers ☐ Sores on your lips/mouth ☐ Fever blisters

Do your gums bleed after brushing?

◯ Yes ◯ No ◯ Sometimes

Are your gums often sore or tender?

◯ Yes ◯ No ◯ Sometimes

Does food catch between your teeth?

◯ Yes ◯ No ◯ Sometimes

Do you ever experience dry mouth?

◯ Yes ◯ No ◯ Sometimes

Do you clench or grind your teeth?

◯ Yes ◯ No ◯ Sometimes

Do you notice popping, clicking, or soreness of the jaw joint?

◯ Yes ◯ No ◯ Sometimes

Do you smoke or chew tobacco of any form? ◯ Yes ◯ No

If yes, how often?

_____

_____

Do you frequently suck on candies/cough drops or consume sugary beverages over long periods of time? ◯ Yes ◯ No

Do you drink soda pop? ◯ Yes ◯ No

If yes, how many per day? _____

Do you drink:

☐ City water ☐ Well water ☐ Bottled water

☐ Filtered water that removes Fluoride

What would you like changed with the appearance of your teeth?

☐ Whiter ☐ Straighter ☐ Other

Please describe:

_____

_____

_____

Response Date: ____/____/_____