# Dental History

Date of last dental visit:_____ Reason for the visit: _____

Name of the dentist:_____ Date of most recent dental X-rays:_____

Are you presently in dental pain? Y ◯ N ◯

Have you ever had a reaction to dental freezing? Y ◯ N ◯

Do you brush and floss your teeth daily? Y ◯ N ◯

Have you been treated for periodontal disease? Y ◯ N ◯

Do you experience a dry mouth or dry eyes? Y ◯ N ◯

Have you ever experienced an allergic reaction to any jewellery? Y ◯ N ◯

Do you experience jaw joint pain or jaw joint noises? Y ◯ N ◯

Have you been told that you have TMJ problems? Y ◯ N ◯

Name of Dentist:_____

Date of Treatment:_____

Do you have a history of orthodontic treatment? Y ◯ N ◯

Name of Dentist:_____

Date Completed:_____

Do you have a history of root canal treatments? Y ◯ N ◯

Name of Dentist:_____

Location of root canals in your mouth:_____

Have you had teeth extracted? Y ◯ N ◯

Indicate an approximate date for the extractions:_____

Do you have any crowns or fixed bridges in your mouth? Y ◯ N ◯

Name the dentist who inserted crowns:_____

Date of insertion:_____

Location of crowns in your mouth:_____

Are you satisfied with the appearance of your teeth? Y ◯ N ◯

If no, please explain: _____

Are you satisfied with your previous dental treatment? Y ◯ N ◯

If no, please explain: _____

**Date:_____ Patient's Signature:_____**

**Dr. Manning's Signature:_____**