BARRINEAU D.D.S.
Family Dental Care & Wellness

Name: **Date of Birth:** **Today's Date:**

Dental History

Reason for visit_____
Last dental visit_____ **What was done?** _____
Previous dentist name_____ **Previous dentist phone number**_____
How often do you brush your teeth? _____ **Floss?** _____
Is your drinking water fluoridated? _____

Please circle "Yes" or "No for your responses to the following questions.	**Yes**	**No**
Are you currently experiencing dental pain or discomfort?	Yes	No
Are you currently experiencing sensitivity to hot or cold?	Yes	No
Do you wear partials? Date of placement:_____	Yes	No
Do your gums bleed when you brush or floss?	Yes	No
Are your teeth sensitive to cold, hot, sweets or biting?	Yes	No
Does food or floss catch between your teeth?	Yes	No
Is your mouth excessively dry?	Yes	No
Have you had periodontal (gum) surgery?	Yes	No
Have you had orthodontic (braces) treatment?	Yes	No
Have you had problems associated with previous dental treatment?	Yes	No
Are you apprehensive about dental care?	Yes	No
Do you have frequent sore throats?	Yes	No
Do you experience earaches or neck pain?	Yes	No
Do you have any clicking, popping, or discomfort in jaw?	Yes	No
Do you have any difficulty chewing or opening and closing?	Yes	No
Do you clench or grind your teeth?	Yes	No
Do you get sores or ulcers in your mouth?	Yes	No
Have you ever had a serious injury to your face, jaw, teeth, or mouth?	Yes	No
Oral habits: - Thumb/finger habit? - Lip/nail biting habit?	 Yes Yes	 No No
Do you currently wear a night guard?	Yes	No
How do you feel about your smile?		

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