Exceptional Dentistry
Beverly Rose, DMD

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(321) 259-4666

Dental History

Past Experience

When was your last dental visit? _____

When was your last dental cleaning? _____

Are you satisfied with the appearance of your teeth? _____

Have you ever had an upsetting dental experience? _____

Is there anything else you would like us to know about you or your dental history? _____

_____

Dental History

	Present	Past	Never
Are your teeth sensitive to:			
Hot or Cold:	☐	☐	☐
Biting/Chewing:	☐	☐	☐
Sweets:	☐	☐	☐
Have you ever had:			
Orthodontic Treatment:	☐	☐	☐
Plate or Guard:	☐	☐	☐
Periodontic Treatment:	☐	☐	☐
Oral Surgery:	☐	☐	☐
Serious injury to your mouth or head:	☐	☐	☐

General Information

How often do you brush? _____

How often do you floss? _____

What motivated you to come see us? _____

What concerns do you have about your teeth or smile? _____

_____

Dental Health Habits: Please select the answer that best describes how you are affected by each of the following habits/behaviors:

	No, Never Have	Yes, Do Currently	Did Previously
Grind Teeth:	☐	☐	☐
Bite Cheek:	☐	☐	☐
Tongue Thrust:	☐	☐	☐
Mouth Breather:	☐	☐	☐
Bulimia/Anorexia	☐	☐	☐
Pipe use:	☐	☐	☐
Smokeless Tobacco:	☐	☐	☐
Thumb/finger sucking:	☐	☐	☐
Toothpick :	☐	☐	☐
Chewing Gum	☐	☐	☐
Candy:	☐	☐	☐
Soft Drinks:	☐	☐	☐
Other:	☐	☐	☐

Please describe: _____