VIRUET PERIODONTICS
IMPLANTS - LASER THERAPY

DENTAL HISTORY FORM

First Name: _____ **Last Name:** _____ **Date of Birth:** ___/___/_____

In the following sections, please select whichever applies. Your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your initial visit you may be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

REFERRING DENTIST: _____ Phone #: _____

CHIEF COMPLAINT: _____

Have you ever had any of the following procedures done?

Extractions	☐Yes	☐No	Root canal therapy	☐Yes	☐No
Fillings	☐Yes	☐No	Gum graft	☐Yes	☐No
Crown and bridges	☐Yes	☐No	Bone graft	☐Yes	☐No
Teeth whitening	☐Yes	☐No	Sinus grafting	☐Yes	☐No
Orthodontic (Braces) Treatment	☐Yes	☐No			
Removable dentures (complete/partial)	☐Yes	☐No	When was your present denture delivered?		
Dental Implants	☐Yes	☐No	If yes, what year implants were placed?		
Wisdom teeth removal	☐Yes	☐No	If yes, how long ago?		

GENERAL HABITS

Do you clench or grind your teeth?	☐Yes	☐No	
Do you bite your lips or cheeks frequently?	☐Yes	☐No	
Do you eat sweets (Ex. Hard candy)?	☐Yes	☐No	If, yes how frequent? _____
Do you drink soda?	☐Yes	☐No	If, yes how frequent? _____
Do you drink coffee or tea?	☐Yes	☐No	If, yes how frequent? _____
Do you chew lemons or other fruits?	☐Yes	☐No	If, yes how frequent? _____
Do you chew ice?	☐Yes	☐No	If, yes how frequent? _____
Do you smoke?	☐Yes	☐No	How many cigarettes per day? _____
Do you chew tobacco?	☐Yes	☐No	How many times per day? _____
Do you drink alcoholic beverages?	☐Yes	☐No	How many drinks per day? _____

ORAL HYGIENE HABITS

How often do you brush your teeth? _____ Do you use a manual or electric toothbrush? _____
Brand: _____

How often do you floss? _____

How often do you use a mouthwash? _____

Do you clean under your bridges?	☐Yes	☐No
Do you use interdental brushes?	☐Yes	☐No
Do you use a Waterpik?	☐Yes	☐No
Do you do oil pulling?	☐Yes	☐No

Do your gums bleed while brushing or flossing?	☐Yes	☐No	
Are your teeth sensitive to cold, hot, sweets or pressure?	☐Yes	☐No	
Do you feel spontaneous pain on any of your teeth?	☐Yes	☐No	
Do you have pain on chewing on any of your teeth?	☐Yes	☐No	
Do you have any sores or lumps in or near your mouth?	☐Yes	☐No	
Does food frequently get caught between your teeth?	☐Yes	☐No	
Do you have any loose teeth or have they ever shifted?	☐Yes	☐No	
Do you wear a nightguard?	☐Yes	☐No	
Do you snore when sleeping?	☐Yes	☐No	If yes, do you wear a mouth appliance at night? ☐Yes ☐No
Do you have headaches or migraine?	☐Yes	☐No	
Have you had any pain in your jaw area?	☐Yes	☐No	
Have you ever had difficulty opening or closing your jaw?	☐Yes	☐No	
Does your jaw ever get locked?	☐Yes	☐No	
Have you ever been told you have TMJ problems?	☐Yes	☐No	
Have you ever had a head, neck or jaw injury?	☐Yes	☐No	
Do you suffer from neuralgia?	☐Yes	☐No	
Do you have a gummy smile?	☐Yes	☐No	
Do you have dry mouth?	☐Yes	☐No	
Do you have a history of dental trauma?	☐Yes	☐No	
Have you ever had a biopsy done in your mouth?	☐Yes	☐No	How long ago? _____
Have you ever been diagnoses with Lichen planus, Pemphigus, Pemphigoid or any other soft tissue lesions?	☐Yes	☐No	

PERIODONTAL HISTORY

Have you ever been diagnosed with periodontal ("gum") disease? ☐Yes ☐No

If yes, at what age were you diagnosed? _____

Have you ever had deep cleanings done? ☐Yes ☐No If yes, how long ago? _____

Have you ever had periodontal ("gum") surgery done? ☐Yes ☐No If yes, how long ago? _____

Do you have any family history of periodontal disease? (Grandparents, Parents or Siblings) ☐Yes ☐No

If you have a dental problem, please describe: _____

Do you have any concerns about having dental treatment? ☐Yes ☐No If yes, please explain: _____

Are you happy with the appearance of your teeth? ☐Yes ☐No If yes, please explain: _____

Do you ever feel nervous about visiting a Dentist? ☐Yes ☐No If yes, please explain: _____

GENERAL DENTIST: _____ Phone #: _____

Date of your last x-rays: _____ Date of your last cleaning: _____ Date of your last dental exam: _____

Frequency of your dental maintenance? ___ Every 3 months ___Every 6 months ___Other: _____

Are you a seasonal Florida resident? ☐Yes ☐No If yes, months you are in Florida? _____

Do you see general dentist in another state? ☐Yes ☐No Name: _____ Phone #: _____

Do you see a periodontist in another state? ☐Yes ☐No Name: _____ Phone #: _____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or her staff responsible for any errors or omissions that I may have made in completion of this form. I accept full financial responsibility for all services rendered.

Patient Signature: _____ Date: _____

(If under 18, Parent or Guardian Signature required)