Drew Heberer Family Dentistry
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(919)781-0056

Patient Name:_____
DOB:_____
TODAY'S DATE:_____

DENTAL HISTORY

1. What is your major dental concern? _____
2. Date of your last visit to a dentist: _____
3. Date you last had dental xrays taken:_____
4. Have you always had your teeth cleaned at least once a year?_____
5. Is there fluoride in your drinking water?_____
6. Do you use any form of fluoride?_____
7. Do you drink tap or bottled water exclusively?_____
8. Have you ever fainted during a dental visit?_____
9. Have you ever had an unusual reaction following dental treatment?_____
10. Have you had prolonged bleeding following dental treatment?_____
11. Have you had injury/surgery to your teeth, jaws or face?_____
12. Have you ever had complications following dental treatment?_____
13. Are some of your teeth becoming loose?_____
14. Are your teeth sensitive to cold, hot, pressure?_____
15. Do you experience pain or clicking in your jaw?_____
16. Do you chew ice, bite fingernails?_____
17. Do you have history of grinding or clenching your teeth?_____
18. Do you wear an athletic guard during sport play?_____