PORTO FINO
DENTAL
FAMILY, COSMETIC, & RESTORATIVE DENTISTRY

Dental History

Is the patient a minor? Yes/No
Is this your child's first dentist visit? Yes/ No

Does your child have any of the following?
No/Yes Cavities/ Decay?
No/Yes Lip Sucking / Biting?
No/Yes Speech Problems?
No/Yes Nail Biting ?
No/Yes Pacifier / Thumb / Finger Sucking?
No/Yes Mouth Breathing?
No/Yes Tongue Thrust?
No/Yes Nursing / Bottle Habits?
No/Yes Jaw Problems?
No/Yes Grinding Teeth?
No/Yes Has the patient ever had orthodontic treatment (Braces)?
No/Yes Has the patient ever had any pain/tenderness in their jaw joint (TMJ/TMD)?

Reason for visit:: _____
Date of last dental visit:
0 – 6 months ago / 6 months - 1 Year Ago / 1-2 Years / More than 2 years ago
Date of last dental X-rays: _____
How often do you floss?:
2-3 times a week /Daily / Never/ Weekly
How often do you brush?:
2-3 times a week / 2-3 Times a day /Daily / Never

No/Yes Bad Breath?
No/Yes Bleeding, Red, Swollen Gums?
No/Yes Broken/Loose teeth or fillings?
No/Yes Clicking or popping jaw?

No/Yes Grinding teeth
No/Yes Pain around ear/side of face?
No/Yes Sores/Blisters in mouth

List any other dental concerns/pain: _____

What did you like the most about your previous dental office?:

_____

What did you like the least about your previous dental office?:

_____

No/Yes Are you interested in whitening your smile?

Are you happy with your smile? If not, what would you change?:

_____

_____
Todays Date

_____ _____
Patient Print Name Patient Signature

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