NORTHPORT
PERIODONTICS
& IMPLANT DENTISTRY

920 Rose Drive
Northport, AL 35476

(205) 737-4667
info@northportperio.com

First Name **Middle Initial** **Last Name**

_____ _____ _____

Dental History

What is the reason for your dental visit today?

Are you currently experiencing dental pain or discomfort?

◯ Yes Please explain: _____

◯ No

Date of Your Last Dental Exam: _____

What was done at that exam? _____

Date of Last Dental X-Rays: _____

How do you feel about your smile?

_____

Do your gums bleed when you brush or floss?

◯ Yes

◯ No

Are your teeth sensitive to cold, hot, sweets, or pressure?

◯ Yes

◯ No

Is your mouth dry?

- ○ Yes
- ○ No

Have you had any periodontal treatment including deep cleanings?

- ○ Yes
- ○ No

Have you ever had orthodontic (braces) treatment?

- ○ Yes
- ○ No

Have you had any problems associated with previous dental treatment?

- ○ Yes
- ○ No

Do you have any clicking, popping, or discomfort in the jaw?

- ○ Yes
- ○ No

Do you brux, clench, or grind your teeth?

- ○ Yes
- ○ No

Do you have sores or ulcers in your mouth?

- ○ Yes
- ○ No

Do you wear dentures or partials?

- ○ Yes
- ○ No

Have you ever had a serious injury to your head or mouth?

- ○ Yes
- ○ No

_____ _____

Patient Signature **Date**