Ross Dental Group
Something to Smile About

Ross Dental Group
3825 Kraus Lane, Unit J
Fairfield, OH 45014
513-738-2606

DENTAL HISTORY

Patient's Name _____Date of Birth _____ Today's Date _____

- When was your last dental visit? _____ (If you are a returning patient that has not been seen at any other dental office since your last visit in our office, write 'here' & skip the next three questions.)

-What was done then? _____

-If your last dental visit was more than one year ago, what has kept you away? _____

-Have you had a panoramic or complete mouth series of dental xrays taken recently? Yes No
If yes, when / Where? _____

-How often do you brush your teeth? _____ How often do you floss your teeth? _____

-What kind of tooth brush do you use? Manual Electric toothbrush

Y N Have you ever had orthodontics? If yes, when?
_____
Y N Do you still have your wisdom teeth?
Y N Do your gums bleed while brushing or flossing?
Y N Are your teeth sensitive to hot or cold liquids or foods?
Y N Do you feel pain in any of your teeth? _____
_____
Y N Do you have any sores or lumps in or near your mouth? _____
Y N Have you had any head, neck or jaw injuries?
_____
Y N Have you experienced any of the following problems in your jaw?
____ Clicking
____ Pain (joint, ear, side of face)
____ Difficulty opening or closing your mouth
____ Difficulty chewing

Y N Do you have frequent headaches?
Y N Do you bite your lips or cheeks frequently?
Y N Have you noticed any loosening of your teeth?
Y N Does food tend to get caught between your teeth?
Y N Have you ever had periodontal treatment (gums)? If yes, provide details _____
_____
Y N Do you clench or grind your teeth?
Y N Have you ever worn a mouth guard or any other Appliance used for grinding your teeth?
Y N Do you wear dentures or partials? If yes, date of placement? _____
Y N Do you ever have a bad taste in your mouth?
Y N Do you have dry mouth?
Y N Do you suffer from cold sores?
Y N Have you ever whitened your teeth?
Y N Do you snore?
Y N Are you a mouth breather?

Is there anything that you would like to change about your teeth or your smile? _____
_____
_____

Are you a fearful dental patient? If yes, how can we make your visit more comfortable for you? _____
_____

PERSONAL INFORMATION

Tell us a little about yourself _____
_____

We thank you for taking the time to answer these questions.
We look forward to getting to know you better.