In-House Dental Care PO BOX 6951 Huntington Beach, CA 92615 P. (949) 339-5373 F. (949) 339-5383

DENTAL HISTORY

Patient's Name: _____ DOB: _____

Name of Responsible Party: _____
(or Power of Attorney / POA)

Contact Number of Pt/POA: _____

Name of previous Dentist: _____ Phone: _____

Date of your last visit? _____ Last x-rays? _____

How often do you brush? _____ Floss? _____

Do you have any dental problems now? Yes No If yes, please describe:

_____

_____

Do you wear Dentures? Yes No

If YES What Type of Dentures are your wearing? Full Upper Full Lower Partial Upper Partial Lower

If YES how old are they and are you having any problems with them?

_____

_____

Are your teeth sensitive to the following?

HOT or COLD? Yes No Sweets? Yes No Biting / Chewing? Yes No

Do your gums hurt or bleed? Yes No If yes, please describe:

_____

_____

_____