In-House Dental Care 9506 Hamilton Ave. Huntington Beach, CA 92646 P. (949) 339-5373 F. (949) 339-5383

DENTAL HISTORY

Patient's Name: _____

Name of Responsible Party: _____

(or Power of Attorney / POA)

Contact Number: _____

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

_____

_____

_____

Are your teeth sensitive to:

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

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

_____

_____