Cordido Dental Pros

Your Healthy and Customized Smile.

DENTAL HISTORY

Patient Name: _____ DOB: ____/____/_____
Last First Middle

What brings you to the clinic today? _____

Do you have any dental pain? _____

Are you receiving routine dental care? __ Yes __ No

Date of last Dental Visit? _____ Reason _____ Last Dental X-rays _____

Are your teeth sensitive to hot, cold, sweet, pressure? _____

Do you have any swelling(s) in your mouth? _____

Are your teeth loose or shifting? _____

Have you felt any change of your bite? _____

Are you satisfied with the appearance of your teeth? What would you like to change? _____

_____

PAST DENTAL TREATMENT:

- ☐ Orthodontics (braces) _____
- ☐ Oral Surgery (extractions, etc) _____
- ☐ Periodontics (gum treatment) _____
- ☐ Endodontics (Root canal) _____
- ☐ Restorations (Fillings) _____
- ☐ Crowns and Bridges _____
- ☐ Partial Dentures _____
- ☐ Full Dentures _____
- ☐ Dental implants _____

Dentures and/or partial dentures:

How long worn? _____ Age of present denture? _____ How many past dentures? _____

Any current problem? _____ Reason for Replacement _____

(469) 466-2371 ★ 7709 San Jacinto Pl. Ste 200. Plano, Texas.

Have you ever had problem/complications with past dental care? Please explain _____
_____

Did you drink fluoridated drinking water in your childhood? _____ Where did you grow up? _____

What was the source of your drinking water? _____

ORAL HYGIENE

Type of toothbrush that you use: __ Hard __ Med __ Soft __ Extra Soft __Electric. Brushing #times/day _____

Flossing # times/day: _____ Toothpaste type: __Fluoride __ Whitening ___Tartar Control __ Other _____

Other fluoride

____ Rinse (OTC)

____ Prescription __ gel ___ Toothpaste __ tablets

____ Other

Mouth Rinse # times/day _____ Brand _____

Other Oral self-care _____

Salivary Function

- ☐ Does your saliva feels thick or ropey?
- ☐ Does your mouth feels dry?
- ☐ Do you have difficulty chewing food?
- ☐ Do you have difficulty speaking?
- ☐ Do you have excess saliva?

Is there any other dental concern that has not been discussed? Please explain. _____
_____
_____
_____

SIGNATURE OF PATIENT: I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand that it is very important to report any changes or dental status to the dentist at the earliest possible time, and I agree to do so. I give permission to the dentist to obtain from my physician any additional information regarding my medical history needed to provide me the best dental treatment possible.

Signature: _____ Date: _____
If other than the patient, indicate relationship: parent or legal guardian _____