Jonathan M. Jenkins, D.D.S., M.S.

DENTAL HISTORY

Patient Name	Medical Alert

What was done at your last dental visit? General Dentist s name Referring Dentist How often do you see your dentist? How often do you brush your teeth? How often do you floss? What other dental aids do you use? (waterpik, electric toothbrush, toothpick) Do you have dental problems? Yes No If yes, please describe Please circle the correct response to: Are any of your teeth sensitive to: Have you had orthodortic treatment Yes No Have you had orthodortic treatment Yes No Have you had peridontal treatment Yes No Have you had peridontal treatment Yes No Have you had peridontal treatment Yes No Have you had a morth guard or bit plate Yes No Have you noticed any mouth doors or bad tasks Yes No Have you had a serious head or mouth injury Yes No Have you had a serious head or mouth injury Yes No Have you had orthodortic treatment Yes No Have you had a serious head or mouth injury Yes No Have you had a serious head or mouth injury Yes No Have you had a serious head or mouth injury Yes No Have you had peridontal treatment Yes No Have you had peridontal further Yes No Yes No Have you had a serious head or mouth injury Yes No Have you had peridontal further Yes No Have you experienced clicking or popping Yes No Have you had peridontal further Yes No Have you experienced clicking or popping Yes Have you had peridontal further Yes No Have you had headed or mestaches Yes No	What is the reason for your visit today?		-02.00 <u>-0</u> 0100			
Referring Dentists How often do you see your dentist? How often do you brush your teeth? How often do you brush your teeth? What other dental aids do you use? (waterpik, electric toothbrush, toothpick) Do you have dental problems?	Date of last dental visit Last dental cle	aning		Last full mouth x-rays		
Referring Dentists How often do you see your dentist? How often do you brush your teeth? How often do you brush your teeth? What other dental aids do you use? (waterpik, electric toothbrush, toothpick) Do you have dental problems?	What was done at your last dental visit?					
How often do you brush your teeth?	General Dentist's name					
How often do you brush your teeth?	Referring Dentist					
What other dental aids do you use? (waterpik, electric toothbrush, toothpick) Do you have dental problems? Yes No If yes, please describe Please circle the correct response to: Are any of your teeth sensitive to:	How often do you see your dentist?					
Please circle the correct response to: Are any of your teeth sensitive to:	How often do you brush your teeth?			How often do you floss?		
Please circle the correct response to: Are any of your teeth sensitive to: Hot or cold Sweets Yes No Have you had orthodontic treatment Yes Have you had periodontal treatment Yes Have you noticed any mouth odors or bad tastes Do you frequently get cold sores, blisters or lesions Do your gums bleed or hurt Have you noticed any loose teeth or change in your bite Does food tend to get caught between your teeth Ob you blod foreign objects in your teeth Do you blod foreign objects in your teeth Do you mouth breathe while awake or asleep More than 2 alcoholic beverages per day What? What? No If yes, please describe Have you had orthodontic treatment Yes No Have you had periodontal treatment Yes No Have you had a mouth guard or bite plate Have you had a serious head or mouth injury Yes No Have you had a serious head or mouth injury Yes No Have you had a serious head or mouth injury Yes No Have you had a serious head or mouth injury Yes No Have you had orthodontic treatment Yes No Have you had orthodontic treatment Yes No Have you had orthodoral surgery Yes No Have you had a serious head or mouth injury Yes No Have you had a serious head or mouth injury Yes If Yes, please describe, Have you experienced clicking or popping Have you wath addifficulty chewing Yes No Soreness/horseness in throat Yes No Ob you smoke or cheeks regularly Yes No Do you smoke or cheek regularly Yes No More than 2 alcoholic beverages per day Yes No Do you smoke or cheek tobacco Yes No Would you like to keep your teeth for life Yes, what is your biggest concern Have you experienced clicking or popping Yes Have you experienced pain (joint, ear, face) Yes No Do you selench or grind your teeth Yes No Do you statisfied with your teeth's appearance Yes Yes No Do you selench or grind your teeth Yes No Do you felench or grind your teeth Yes No Do you felench or cheeks regularly Yes No Do you felench or grind your teeth Yes No Do you felench or grind your teeth Yes No Do you felench or grind your teeth Yes No Do you felench or cheeks regularly Yes N	What other dental aids do you use? (waterpik, electric toothb	orush, t	ooth	pick)		
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s there anything else about having dental treatment that you would like us to know about? Yes No						
z 🕦 i S Milani wakatan mamakata di Tanta dan di Matana 1770 - 1770 - 1770	s there anything else about having dental treatment that	you w	ould	like us to know about? Yes No		