BAYVIEW DENTAL ASSOCIATES, P.A.

DENTAL HISTORY

Patient Name:_____ Date:_____

Are you having any discomfort or problems at this time? YES NO

If so, what problems? _____

How long since you have been to a dentist? _____

What was done at your last visit? _____

Did you have x-rays? _____

Date of last full mouth x-rays _____

Name of your previous dentist _____

Address of your previous dentist _____

Have you lost any teeth? YES NO

Why were the teeth lost? _____

Have they ever been replaced? YES NO

Are your teeth sensitive to

heat_____cold_____sweets_____pressure_____

Do you have problems with teeth/fillings breaking? YES NO

Have you ever had your teeth straightened? YES NO When?_____

Do you have any loose, tipped or shifting teeth? (circle)

How often do you brush_____floss_____?

Do you use any other cleaning aids or rinses? YES NO

If so, what type _____

Do your gums bleed? YES NO When?_____

Have you ever had gum treatments? YES NO When?_____

Do you have any pain, clicking or popping noises in your jaw joint? YES NO

Are you aware of grinding or clenching your teeth? YES NO

Have you ever had TMJ treatment? YES NO

Do you have any lump or swelling in your mouth? YES NO

Do you have any fear of having dentistry done? YES NO

If yes, why? _____

Have you ever had an unusual reaction to local anesthesia? YES NO

Have you ever had any complications following dental treatment? YES NO Explain:_____

Are you satisfied with the appearance of your teeth? YES NO

BAYVIEW DENTAL ASSOCIATES, P.A.

CLINICAL EXAMINATION CHARTING

	6																6	
	4																4	
	2																2	

DATE 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

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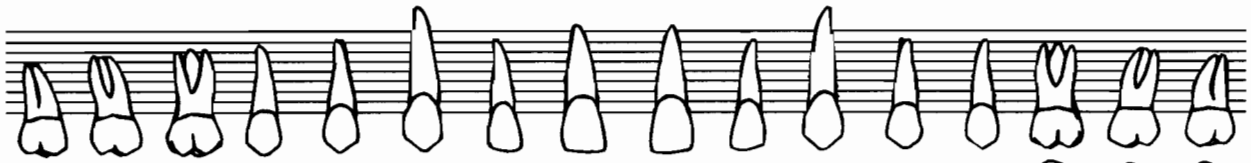

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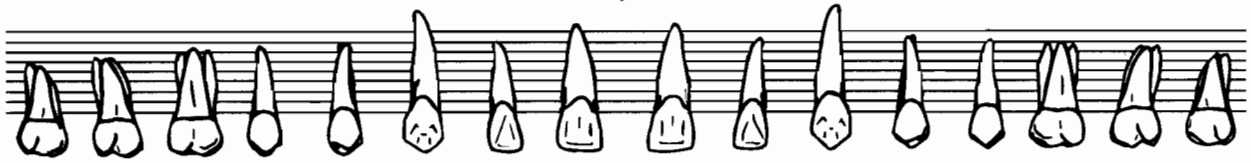

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ENCIRCLE BLEEDING AND / OR EXUDATE

	6																6	
	4																4	
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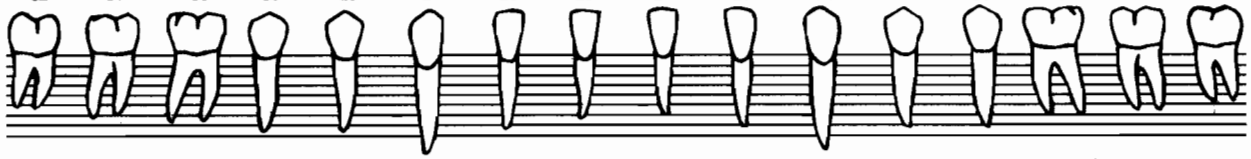

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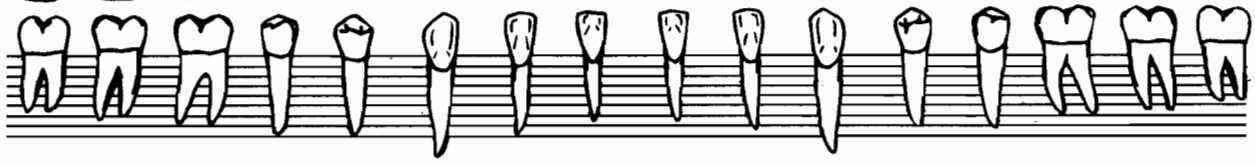

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	5																5	

Furcations
V = I
Δ = II
▲ = III
Mobility
I, II, III

Bleeding Points
Circle Tooth Number
Suppuration/Exudate
*

II = Open Contact
N = Marginal Ridge Discrepancy
MAG = Minimal Attached Gingiva
NAG = No Attached Gingiva

NOTES: