Energy Square Prosthodontics / Central Alberta Prosthodontics

Registered Specialists in Prosthodontics and Restorative Dentistry

Dental History

Date of last dental visit ______ Day/Month/Year

Reason for the visit ______

Date of most recent dental x-rays ______ Day/Month/Year

Name of previous dentist ______

	Yes	No
Are you presently in dental pain?	◯	◯
Have you ever had a reaction to dental freezing?	◯	◯
Do you brush and floss your teeth daily?	◯	◯
Have you been treated for periodontal disease?	◯	◯
Do you experience a dry mouth or dry eyes?	◯	◯
Have you ever experienced an allergic reaction to jewelry?	◯	◯
Have you ever experienced jaw joint pain or jaw joint noise?	◯	◯
Have you been told that you have TMJ problems?	◯	◯

If yes, name of dentist: ______

Date of treatment ______ Day/Month/Year

Do you have a history of orthodontic treatment (ex. braces)? ◯ ◯

If yes, name of dentist: ______

Date completed ______ Day/Month/Year

Do you have a history of root canal treatment? ◯ ◯

If yes, name of dentist: ______

Location of root canal(s) in your mouth ______

Have you had teeth extracted? ◯ ◯

Approximate date of extractions ______ Day/Month/Year

Location of extracted teeth in your mouth ______

Do you have crown(s) or fixed bridge(s) in your mouth? ◯ ◯

Name of dentist who inserted crown(s) or bridge(s) ______

Location of crown(s) or bridge(s) in your mouth ______

Date of insertion ______ Day/Month/Year

Are you wearing complete dentures or partial dentures? ◯ ◯

If yes, name of dentist: ______

Date of insertion ______ Day/Month/Year

Are you satisfied with the appearance of your teeth? ◯ ◯

If no, please explain: ______

Are you satisfied with your previous dental treatment? ◯ ◯

If no, please explain: ______

Date ______ Patient's Signature ______ Dentist's Signature ______