Take a
BITE...
OUT OF YOUR DENTAL BILLS

Client Dental History

Name: ______________________________________ **Date:** D______/M________/Y_________

1) Is this your first Dental Hygiene cleaning? Y N

If "No"

When was your last Dental Hygiene Cleaning? M_________/Y_________

How often do you have a cleaning? Every: 3mo 6mo 12mo Other: _________

2) How many times a day do you brush your teeth? ___________

Electric or Manual

3) How often do you floss your teeth? ___________

4) How often do you brush your tongue? __________

5) Do you use other dental aids? ProxaBrush Rubber Tip

Other: _________ SulcaBrush Flossing Aids

6) Do you use a mouth rinse? ____

How often? __________ Brand: _________

7) Do your gums bleed when you brush? Y N

8) Do you feel you have bad breath? Y N

9) Has anyone taught you how to care for your teeth? Y N

10) Are there any growths or sore spots in your mouth? Y N

11) Have you ever been diagnosed with periodontal / gum disease? Y N

12) Have you ever been advised to take antibiotics before dental cleaning? Y N

13) Are you currently undergoing any medical treatments? Y N

If "Yes" please indicate: ____________________________

14) Do you ever have a dry or burning mouth? Y N

15) Do you breath from your mouth while you are awake or asleep? Y N

16) Do you have any present dental problems? (sensitivity, bleeding, sore gums) Y N

If "Yes" please indicate: ______________________________

17) Do you grind or clench your teeth? Y N

18) Do you have pain in your jaw or joint? Y N

19) Are there any dental or medical concerns not listed or additional information? Y N

Please indicate:

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