Arthur Kezian D.D.S.

Patient Dental History

Date___/___/___

Patient's Name (Last)_____(MI)_____(First)_____

Most recent dental exam?___/___/___
Most recent dental x-rays?___/___/___
How often do you have your teeth cleaned? 3 months___4 months___6 months___longer?___
How would you describe your current dental health?_____
How do you feel about the appearance of your teeth?_____
What is your immediate dental concern?_____

Please answer Yes or No to the following and provide any additional information in the explain section.

Do you like the color of your teeth? Yes___No___ Too light___Too dark___
Do you like the shape of your teeth? Yes___No___
Do you like your smile? Yes___No___ Explain:_____
Do your gums look and feel healthy? Yes___No___ Explain:_____
Are you happy with the color of your fillings? Yes___No___ Explain:_____
Are you happy with other restorations in your mouth (crowns, veneers, bonding)? Yes___No___
Explain:_____
Do you have any particular dental anxiety or fears? Explain:_____
Do you have any problems with dental anesthesia? Yes___No___ Explain:_____
Do you ever have an unpleasant odor or taste in your mouth? Yes___No___
Explain_____

Do you have dry mouth, throat or eyes? Yes___No____ Explain:_____
Do you have jaw problems (TMJ/Temporomandibular joint)? Yes___No___
Explain:_____
Do you have difficulty opening your mouth widely? Yes___No___ Explain:_____
Do you awaken with stiffness in your mouth or jaw? Yes___No___ Explain:_____
Do you get tension headaches? Yes___No___ Explain:_____
Do you clench or grind your teeth? Yes___No___ Explain:_____
Do your gums bleed when you brush? Yes___No___
Are your teeth sensitive to cold, hot, sweets or pressure? Yes___No___

Patient Signature: _____ Date: _____

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