LINDSBORG FAMILY DENTAL CARE

Erik J. Peterson, DDS | 101 N. Harrison, PO Box 311 • Lindsborg, KS 67456-2204 (785)227-2299

DENTAL HISTORY

Patient Name:

_______________ Last _______________ First ____ MI

_______________ Preferred Name

Name and Phone Number of previous Dentist

Approximate date(s) of most recent dental exam and dental x-rays

Why did you leave your last dentist?

I routinely see a dentist every

- ◯ 3 mos
- ◯ 4 mos
- ◯ 6 mos
- ◯ 12 mos
- ◯ not routinely

How would you rate the condition of your mouth?

- ◯ Excellent
- ◯ Good
- ◯ Fair
- ◯ Poor

Do you have any immediate dental concerns, or anything specific to address at your appointment?

Is there anything about the appearance of your smile that you would like to change?

Describe your home dental care routine.

Check all that apply

- [ ] Apprehensive about dental treatment
- [ ] Had any reactions to local anesthetic
- [ ] Sensitivity to hot, cold, sweets, pressure
- [ ] Gums bleed when brushing or flossing
- [ ] Clench or grind your teeth
- [ ] Experience popping and/or clicking of your jaw joint
- [ ] Experience dry mouth
- [ ] Have whitened or bleached your teeth
- [ ] Have/ had braces or othodontic treatment
- [ ] Snore or wake up frequently during the night
- [ ] Had complications from past dental treatment
- [ ] Had trouble getting numb
- [ ] Avoid brushing any part of your mouth
- [ ] Diagnosed and/or treated for gum disease
- [ ] Have frequent headaches, earaches or neck pain
- [ ] Difficulty chewing
- [ ] Food gets trapped between any teeth
- [ ] Have/had a bite appliance
- [ ] Wear dentures (partials or full)

If any conditions selected need further clarification, please explain below

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Please provide any other dental information you feel we should be aware of

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- [ ] ***I verify that all the above information is correct to the best of my knowledge.**

Name and relationship of individual completing this form, if other than patient

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Response Date: ___________