West Kootenay Community TEETH Clinic
A Successful Life Begins with a Healthy Smile

DENTAL HISTORY

Patient's Name _____ Birthdate _____

Address _____
STREET CITY PROVINCE POSTAL CODE

Phone # _____ _____ _____ Email _____
HOME WORK CELL

Former Dentist _____ How long have you been a patient there? _____

Date of last dental treatment? _____ Date of last X-rays _____

Date of last cleaning/checkup appointment _____

Do you routinely have cleanings? Yes ( ) No ( ) How Often?

How often do you brush? ____/____ Floss? ____/____ Do you use fluoridated toothpaste? Yes ( ) No ( )

Have you had any dental implants placed? Yes ( ) No ( ) When? _____

Do you wear any dental appliances? Night Guard Orthodontic Appliance

Complete or Partial Denture Sleep Apnea Appliance

Do you experience any of the following? Please (X) any that apply.

Bleeding/Sensitive Gums	( )	Broken Teeth	( )
Loose Teeth	( )	Dry Mouth	( )
Sensitivity to Hot or Cold	( )	Grinding or Clenching	( )
Popping or Clicking of the Jaw	( )	Frequent Mouth Ulcers	( )

Have you ever consulted any dental specialists? If yes, please list their name and year of treatment.

Endodontist (Root Canal Specialist)	Name _____	Date _____
Orthodontist (Braces/Invisiline)	Name _____	Date _____
Periodontist (Gum Specialist)	Name _____	Date _____
Oral Surgeon	Name _____	Date _____
Prosthodontist(Corwn and Bridge)	Name _____	Date _____

Is there any additional information about your dental history?

Describe _____

_____

_____

I certify that the above information is true and complete to the best of my knowledge.

_____ _____
PATIENT OR GUARDIAN SIGNATURE DATE