

John Vinings D.D.S. PA

**~ Dental History ~**

Patient Name: \_\_\_\_\_  
Preferred Name: \_\_\_\_\_

What is the purpose of today's visit? \_\_\_\_\_  
Are you having any dental discomfort or concern?  
\_\_\_\_\_

Previous Dentist: \_\_\_\_\_

Address: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

Date of last dental care: \_\_\_\_\_  
How long has it been since your last teeth cleaning? \_\_\_\_\_

How often do you brush? \_\_\_\_\_  
Floss \_\_\_\_\_

What other dental aids do you use? (Sonicare, Braun, Proxybrush, Endtuff, etc.) \_\_\_\_\_

Circle any condition that you have had :

Clicking and Popping of Jaw \_  
Grinding or Clenching Teeth \_  
    AM \_ PM \_

Tired Jaw, especially in AM \_  
Teeth hit in front first \_  
Nail Biting \_  
Bad Breath \_  
Sensitive to Sweets \_  
Sensitive to Cold \_

Food collection between Teeth \_  
Pipe Smoking \_  
Periodontal Treatment \_  
Bleeding Gums \_  
Sensitive to Hot \_  
Sensitive When Biting \_

How often do you awaken with head or jaw pain of unknown origin?

\_\_\_\_\_

Have you ever had an adverse reaction to or in conjunction to a medical or dental treatment? \_\_\_\_\_

Please Explain \_\_\_\_\_

\*Have you ever experienced: \*

Have you ever been asked to PRE MED prior to a dental visit?

Problems of prolonged bleeding either from a cut or dental procedure? Yes/No

Do you ever have a bad taste in your mouth? \_\_\_\_\_

Do you have any loose teeth in your mouth? \_\_\_\_\_

Are you interested in a non-surgical way to stop your spouse from snoring? \_\_\_\_\_

Are you interested in whitening your teeth? \_\_\_\_\_

Are you interested in orthodontics? \_\_\_\_\_

Would you be if you did not have to wear the traditional brackets on your teeth? \_\_\_\_\_

Any additional information you feel might be helpful to Dr. Vinings about your dental health

Why did you leave your last dentist? \_\_\_\_\_