Oyster Point Dental

Zachary Duman DDS

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Newport News, VA. 23606

Phone: (757) 596-6216

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PATIENT DENTAL HISTORY

1. Do your gums bleed while brushing or flossing?

Yes No

2. Are your teeth sensitive to hot or cold liquids/foods?

Yes No

3. Are your teeth sensitive to sweet or sour liquids/foods?

Yes No

4. Do you feel pain in any of your teeth?

Yes No

5. Do you have any sores or lumps in or near your mouth?

Yes No

6. Have you had any head, neck, or jaw injuries?

Yes No

7. Have you experienced any of the following problems in your jaw?

a) Clicking (pain, difficulty in opening or chewing)?

Yes No

b) Pain (Joint, ear, side of face)

Yes No

c) Difficulty in opening or closing?

Yes No

8. Do you have frequent headaches?

Yes No

9. Do you clench or grind your teeth?

Yes No

10. Do you bite your lips or cheeks frequently?

Yes No

11. Have you had any difficult extractions in the past?

Yes No

12. Have you had any prolonged bleeding following extractions?

Yes No

13. Have you had any orthodontic therapy? (Braces OR Invisalign)

Yes No

14. Have you ever had instruction on the correct method of brushing your teeth?

Yes No

15. Have you ever been instructed on the care of your gums?

Yes No

16. Have you ever been told that you have Periodontal Disease?

Yes No

17. Do you have a Fear of Dentistry?

Yes No

a) Rate FEAR from 1-10: _____

18. Do you have any X-Rays from a previous Dentist that you would like sent over? (Certain X-Rays may only be covered every 3-5 years by your insurance)

Yes No

a) If 'Yes', please list the Office name AND Phone number:

_____

Please Read: I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Signature: _____

Date: _____