JENNIFER KLUTH, DMD LLC 518-374-6845

DENTAL HISTORY

Name:_____ Date_____
Have you had cleanings/exams on an ongoing basis?_____ Last Dental Appointment_____
Former Dentist & Address_____

PLEASE INDICATE IF YOU HAVE A HISTORY OF ANY OF THE FOLLOWING:

Allergies to any metals_____	YES	NO
Avoid chewing in certain areas of your mouth_____	YES	NO
Bleeding, swollen or sore gums_____	YES	NO
Blisters, sores or growths in or around your mouth_____	YES	NO
Breathe through your mouth a lot_____	YES	NO
Burning sensation on your tongue_____	YES	NO
Dry mouth_____	YES	NO
Grinding your teeth_____	YES	NO
Jaw pain or pain around ears when chewing or opening wide_____	YES	NO
Lip or cheek biting_____	YES	NO
Orthodontic treatment _____	YES	NO
Pain upon brushing_____	YES	NO
Pain upon eating_____	YES	NO
Periodontal treatment_____	YES	NO
Sensitivity to cold, heat or sweets_____	YES	NO
Snoring_____	YES	NO
Smoke or use any tobacco products_____	YES	NO
Unpleasant taste or odor in your mouth_____	YES	NO
Do you often catch food between your teeth_____	YES	NO
Do you have any broken or loose teeth or fillings_____	YES	NO
Are you dissatisfied with your teeth in any way_____	YES	NO
Are you dissatisfied with the appearance of your teeth (Alignment, color, shape, spaces)_____	YES	NO
Do you have fillings that show in your front teeth when you smile_____	YES	NO

What is most important to you when you have your teeth restored?
Cost_____ Cosmetics_____ Longevity of the restoration_____

Rate your smile on a scale of 1-10 (with ten as the most satisfied)_____		
Have you been instructed regarding proper home care_____	YES	NO
Do you frequently snack between meals_____	YES	NO

How often do you brush?_____x/day Floss?_____x/day

Do you want to learn to control dental disease and retain your teeth_____	YES	NO
Do you get frustrated because you always have something to be treated or repaired when you visit the dentist_____	YES	NO

When was your last *thorough examination* with full mouth x-rays?_____
What prompted you to seek dental care at this time?_____

Our office is committed to providing you with the best possible care. We must emphasize that as a dental care provider, our relationship is with YOU, not your insurance company. While filing of insurance claims is a courtesy that we extend to our patients, ALL CHARGES ARE YOUR RESPONSIBLILTY from the date the services are rendered.

Signature_____ Date_____