Chesterfield Family & Cosmetic Dental Center
Dr. Roger Buzbee

PATIENT DENTAL HISTORY

Reason for today's visit:_____

Date last seen by dentist: _____

Date of last dental x-rays: _____ Date of last cleaning: _____

Have you ever been told or been treated for periodontal disease: Y N When: _____

How often do you brush your teeth: _____How often do you floss: _____

DO YOU HAVE ANY OF THE FOLLOWING?

Mouth odor or bad taste:	Y N	Bleeding Gums:	Y N
Loose teeth:	Y N	Broken teeth or broken fillings:	Y N
Does food collect between your teeth:	Y N	Chew on one side of your mouth:	Y N
Are your teeth sensitive:	Y N		

If yes, explain – Biting, biting down, chewing, sweets, or other: _____

_____

Clicking or popping in jaws:	Y N	Grinding teeth:	Y N
Jaw pain or tiredness:	Y N	Difficulty opening or closing:	Y N
Headaches neck aches or shoulder aches:	Y N	Sore muscles:	Y N
Do you currently or have you ever wore a night guard:	Y N	Orthodontic retainer:	Y N

Have you ever had orthodontic treatment: Y N Treating Dr. _____

Have you ever had oral surgery: Y N Treating Dr. _____

Are you satisfied with your teeth's appearance? Y *N If no explain*: _____

_____

Are you nervous about dental treatment: Y N *If so what is your biggest concern?* _____

_____

Any other information you would like Dr. Buzbee to know: _____

Patient Name: _____**Date:** _____