OAK KORNER DENTAL
LET'S START WITH A SMILE

Dr. Erwan Jerger
123 Trafalgar Road
Oakville, ON, L6J-3G4

DENTAL HISTORY FORM

Please circle the appropriate answer for each condition/disease.

1. Have you had any serious problem(s) with any previous dental treatment?	Y	N
2. Have you ever had an injury to your face, jaw, or teeth?	Y	N
3. Do you ever feel like you have a dry mouth?	Y	N
4. Have you ever had an unusual reaction to local anesthetic (numbing)?	Y	N
5. Do you wear full or partial dentures?	Y	N
6. Have you had any teeth replaced with a dental implant(s)?	Y	N
7. Have you had any teeth replaced with a fixed bridge(s)?	Y	N
8. Have you ever had any of the following treatment(s)?		
☐ Gum/periodontal treatment	Y	N
☐ Orthodontics (braces)	Y	N
☐ Endodontics (root canal)	Y	N
☐ Extractions (teeth removed)	Y	N
☐ Bleaching/whitening	Y	N
9. Do you have any piercings in the head and neck area?	Y	N

If yes, when were they done?_____ Where is/are the piercings?_____

Explain any yes answers:_____

_____

OAK KORNER DENTAL
LET'S START WITH A SMILE

Have you ever had any Lip, Jaw or Gum Augmentation (fillers)? Y N

Check if you have any problems with the following:

- ☐ Bad breath
- ☐ Bleeding, sensitive gums
- ☐ Canker sore or cold sores
- ☐ Clicking or popping jaw: right or left
- ☐ Food trapped between teeth
- ☐ Grinding or clenching teeth
- ☐ Loose teeth
- ☐ Broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity to biting
- ☐ Staining

10. Do you smoke or use tobacco in any form? Y N

What kind? _____ How frequently? _____

How long? _____ Would you like to quit? _____

The answers to the questions listed above are accurate. I understand this information will be used to determine the dental treatment I receive in this dental office and may be shared with other medical offices only as necessary. I will notify this dental office should any information change. I hereby authorize this dental office to perform recommended services.

Patient Name (Handwritten): _____

Patient Signature: _____

Doctor Signature: _____