



A WINNING SMILE DENTAL CENTER

Greg C. Witte, D.M.D.
5417 Robbs Lane • Louisville, KY 40219
(502) 969-9897
www.PerfectWinningSmile.com

DENTAL HISTORY

Patient's Name _____

How long since your last dental visit? _____

Date of your last cleaning _____

Date of last examination with full mouth (16+) x-rays or panorex _____

Name of previous dentist _____

Reason for leaving previous dentist _____

What is the reason for today's visit? _____

Please answer the following:

If you could, what would you change about the appearance of your teeth and smile?

- | | | |
|--|-----|----|
| Do you wear any dental appliance (denture, partial, etc.)? | Yes | No |
| Are you apprehensive of dental treatment? | Yes | No |
| Have you had any instruction on care for your teeth? | Yes | No |
| Have you had any periodontal (gum) treatment? | Yes | No |
| Do your gums bleed or feel tender when you brush? | Yes | No |
| Are you aware of any loose teeth? | Yes | No |
| Are your teeth sensitive to hot, cold, or sweets? | Yes | No |
| Are you aware of clenching or grinding your teeth? | Yes | No |
| Do you have frequent headaches, earaches, or neck pain? | Yes | No |
| Have you worn braces? | Yes | No |
| Do you have any problems with food wedging between your teeth? | Yes | No |
| Do you have any jaw joint pain or stiffness? | Yes | No |

How often do you brush your teeth? _____ Floss your teeth? _____

Are there any other dental problems you are concerned about? _____

Patient Signature: _____ **Date** _____

Must be 18 years or older