Allan J. Milewski, D.D.S., Inc.

Dental Health History

Name: _____ _____

First MI Last Birthdate

Date of Most Recent Dental Exam and Cleaning:_____

Date of Most Recent Dental X-rays: _____

Panorex X-ray Date: _____ Bite Wing X-ray Date:_____ Full Mouth X-ray Date: _____

Name and Address of Former Dentist:

Please check yes or no to the following questions:

| Y | N | |
|---|---|---|
| ☐ | ☐ | Do your gums bleed when brushing or flossing? |
| ☐ | ☐ | Do you feel pain in any of your teeth? |
| ☐ | ☐ | Have you had any head, neck , or jaw injuries? |
| ☐ | ☐ | Do you have frequent headaches? |
| ☐ | ☐ | Do you clench or grind your teeth? |
| ☐ | ☐ | Do you bite your lips or cheeks frequently? |
| ☐ | ☐ | Have you had orthodontic treatment? |
| ☐ | ☐ | Do you have ores ore lumps in or near your mouth? |
| ☐ | ☐ | Have you ever had difficult tooth extractions in the past? |
| ☐ | ☐ | Have you ever had prolonged bleeding following tooth extractions? |

Are your Teeth Sensitive to any of the following?

| Y | N | |
|---|---|---|
| ☐ | ☐ | Hot |
| ☐ | ☐ | Cold |
| ☐ | ☐ | Sweet |
| ☐ | ☐ | Sour |
| ☐ | ☐ | Pressure or Biting |

What is the reason for your visit?

Date:

Signature