Dr Sarkis L. Aznavour
24242 Lyons Ave
Newhall, CA. 91321
Phone: 661. 260.1220
Fax: 661.260.1227
h ealthysmilesnewhall@gmail.com

Confidential Dental History Form

Today's Date_____ Patient name: _____ Birthdate_____

- What is the reason for your visit today?_____
- Previous dentist's name_____ Phone_____
- Date of last dental exam and x-rays_____

Please answer the following questions:

□ yes □ no Are you experiencing pain now? If yes, please describe_____
_____
□ yes □ no Have you had problems with prior dental treatment or a bad experience in the dental office? If yes, please describe_____
□ yes □ no Are you anxious about receiving dental treatment?
□ yes □ no Has your physician or previous dentist ever recommended that you take antibiotics prior to dental treatment (antibiotic prophylaxis)? If yes, why?_____
□ yes □ no Have you ever had orthodontic treatment (braces)? If yes, when?_____
□ yes □ no Have you ever had gum tissue (periodontal) treatment including deep cleanings, root planning or gum surgery? If yes, when?_____
□ yes □ no Have you ever had a biopsy in your mouth? If yes, why?_____
□ yes □ no Have you ever whitened your teeth in the past? If yes, what method?_____
□ yes □ no Do you play sports involving contact? If yes, what sports?_____
□ yes □ no Do you currently wear or previously have worn a nightgaurd or bite appliance?
□ yes □ no Do you snore or have sleep apnea?
□ yes □ no Have you ever had prolonged bleeding after extractions or dental surgery?
□ yes □ no Do you have limited opening of your mouth?
□ yes □ no Are you able to sit for long dental appointments (2-3 hours)?
□ yes □ no Do you have any backaches, neckaches, vertigo, or shortness of breath that will prevent you from
□ yes □ no lying flat on your back? If yes, please describe_____

What concerns do you have with your teeth or smile? (Check all that apply)

□ Jaw joint pain or clicking/popping
□ Clenching, grinding, or bruxing
□ Overbite
□ Underbite
□ Uncomfortable bite
□ Bite adjusted previously
□ Need to chew on one side
□ Difficulty or pain when chewing
□ Difficulty swallowing
□ Speech problems
□ Canker/cold sores
□ Swollen neck glands or face
□ Bleeding or swollen gums
□ Frequent cheek/lip biting
□ Plaque or tartar buildup
□ Pain in teeth or gums
□ Discolored/stained teeth
□ Crowding/crooked teeth
□ Spaces between teeth
□ Missing teeth
□ Tooth shape or size
□ Loose tooth/teeth
□ Unhappy with appearance of teeth
□ Too much gum tissue visible when I smile
□ Concerns with wisdom teeth
□ Food gets caught between teeth If yes, where?_____
□ Tooth sensitivity to hot, cold, sweets, biting or anything else
□ Broken teeth or restorations
□ Old fillings
□ Old crowns
□ Cavities (caries)
□ Loose or uncomfortable dentures
□ Bad breath
□ Bad taste in mouth
□ Dry mouth
□ Other_____

Please check any of the following you would like to discuss with the doctor.

□ Tooth whitening
□ Orthodontic treatment (braces)
□ Dental implants
□ New dentures
□ Veneers (cosmetic dentistry)
□ Tooth colored fillings
□ Tooth colored crowns
□ Preventing cavities
□ At home oral hygiene
□ Treatment during pregnancy
□ Oral hygiene for infants/toddlers
□ Preventing gum disease