Smile Dental Group

7575 Market Crossing
Burnaby, B.C. V5J OA3
Tel :604.433.7444

Dental History

When did you last visit the dentist ?..

What was the purpose of that visit ?..

When did you last have a cleaning ?..

Are you in any pain or discomfort at this time ?...................................

Please Circle
Do you have (or can you obtain) a complete set of x-rays taken in the past 18 months? **Yes / No**
Do any of your teeth hurt? .... **Yes / No**
If yes, please explain ____

Please **circle** if any of your teeth or gums are sensitive or tender:
when you : eat? to cold? to hot? to sweets?

Are there any growths or sores in our mouth? .... **Yes / No**
Do you have any pain or clicking in your jaw joints? .... **Yes / No**
Do you grind or clench your teeth? .... **Yes / No**
Are any of your teeth moving or becoming loose? .... **Yes / No**
Do you catch food in or around any of your teeth or gums? .... **Yes / No**
Do your gums bleed while brushing your teeth? .... **Yes / No**
Do your gums bleed while eating? .... **Yes / No**

Please **circle** if you have previously had any of the following dental treatments:

Orthodontic treatment (braces) Periodontic treatment (gum and bone therapy)
Oral Surgery (extractions or implants) Endodontic treatment (root canal therapy)
Tooth Whitening Porcelain Veneers Bonding

While having previous dental treatment, have you ever (please **circle** if **Yes**):

Fainted? Had an allergic reaction? Had abnormal bleeding? Other complication?

How do you feel about the appearance of your teeth?..
If you could change your smile, how would you change it?...
Do you have any other dental concerns? .... **Yes / No**
If yes, please explain: ____

To the best of my knowledge, all of the preceding answers are true and correct. If I have any changes in my oral health status ,I will inform Smile Dental Group prior to or at my next appointment.
I authorize the dentist to perform diagnostic, dental and oral surgery procedures and services including the use of anesthetic as be necessary. I also understand that I assume responsibility for any and all fees associated with these procedures and services.

________________ ____________________ ______________________
Date Patient's Name Patient's Signature

*If Parent, guardian, please print name: .... Signature:............................