Windsor Family Dentistry

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Name: _____ **Dental History** Date: _____

How may we help you today?

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you require antibiotics before dental treatment? Yes / No Reason: _____

Are you currently in pain? Yes / No	Have you ever had gum Or Periodontal Treatment? Yes / No	Do your gums bleed? Yes / No
Do you now or have you had any pain/ discomfort in your jaw joint (TMJ)? Yes / No	Are you under stress new job, moving, relationships? Yes / No	Have you lost any teeth? Yes / No
Do you like your smile? Yes / No	Is there anything you would like to change about your smile? Yes / No	Are you happy with the color of your teeth? Yes / No
How many times do you: Floss / week? Brush / day?	When was your last dental cleaning?	Are your teeth sensitive to hot, cold or anything else? Yes / No
Have you ever had a serious/difficult problem with any previous dental work? Yes / No	Have you ever had any unfavorable dental experience? Yes / No	
How would you rate your level of dental anxiety? None 0 2 4 6 8 High 10	When was your last dental visit?	How can we accommodate you during your dental visit?

Windsor Family Dentistry offers a wide variety of services to enhance and keep your smile beautiful.

Smile Makeover / Veneers	Extractions / Wisdom Teeth	Night / Sport Guards
Implants	Partials / Dentures	Teeth Whitening
Sedation	Crown and Bridge	

Nearest relative not living with you:

Name: Relationship:

Address: Phone:

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Patient's Signature: Date: