PETER D. GOLD, DDS

518-374-6845

DENTAL HISTORY

Name:______________________ Date______________

Have you had cleanings/exams on an ongoing basis?_____ Last Dental Appointment______________

Former Dentist & Address______________________________

PLEASE INDICATE IF YOU HAVE A HISTORY OF ANY OF THE FOLLOWING:

Allergies to any metals____________	YES	NO
Avoid chewing in certain areas of your mouth____________	YES	NO
Bleeding, swollen or sore gums____________	YES	NO
Blisters, sores or growths in or around your mouth____________	YES	NO
Breathe through your mouth a lot____________	YES	NO
Burning sensation on your tongue____________	YES	NO
Dry mouth____________	YES	NO
Grinding your teeth____________	YES	NO
Jaw pain or pain around ears when chewing or opening wide____________	YES	NO
Lip or cheek biting____________	YES	NO
Orthodontic treatment____________	YES	NO
Pain upon brushing____________	YES	NO
Pain upon eating____________	YES	NO
Periodontal treatment____________	YES	NO
Sensitivity to cold, heat or sweets____________	YES	NO
Snoring____________	YES	NO
Smoke or use any tobacco products____________	YES	NO
Unpleasant taste or odor in your mouth____________	YES	NO
Do you often catch food between your teeth____________	YES	NO
Do you have any broken or loose teeth or fillings____________	YES	NO
Are you dissatisfied with your teeth in any way____________	YES	NO
Are you dissatisfied with the appearance of your teeth (Alignment, color, shape, spaces)____________	YES	NO
Do you have fillings that show in your front teeth when you smile____________	YES	NO

What is most important to you when you have your teeth restored?

Cost_____ Cosmetics_____ Longevity of the restoration____________

Rate your smile on a scale of 1-10 (with ten as the most satisfied)____________

Have you been instructed regarding proper home care____________	YES	NO
Do you frequently snack between meals____________	YES	NO

How often do you brush?________x/day Floss?________x/day

Do you want to learn to control dental disease and retain your teeth____________	YES	NO
Do you get frustrated because you always have something to be treated or repaired when you visit the dentist____________	YES	NO

When was your last *thorough examination* with full mouth x-rays?______________________

What prompted you to seek dental care at this time?______________________

Our office is committed to providing you with the best possible care. We must emphasize that as a dental care provider, our relationship is with YOU, not your insurance company. While filing of insurance claims is a courtesy that we extend to our patients, ALL CHARGES ARE YOUR RESPONSIBLILTY from the date the services are rendered.

Signature______________________________ Date____________