STRATFORD DENTAL
DR. MARK STRAUS, D.D.S.

3035 Ontario Street
Stratford, Ontario N5A 6S5
Phone: 519-273-0580

Dental History

Patient Name:_____ **Date of Birth** _____

Last dental visit? _____ What was done? _____

Last cleaning? _____ How often do you visit a dentist?_____

Last x-rays? _____

What is your immediate concern? _____

Have you ever been advised to take antibiotics before dental treatment? _____Yes ☐ No ☐

Type of Dentistry Experience:

Oral Surgery _____ Yes ☐ No ☐ Dentures _____ Yes ☐ No ☐
Crowns/Veneers _____ Yes ☐ No ☐ Implants _____ Yes ☐ No ☐
Fixed Bridges _____ Yes ☐ No ☐ Orthodontics_____ Yes ☐ No ☐
Periodontal Therapy/Surgery _____ Yes ☐ No ☐ Injury/surgery to face or jaw _____ Yes ☐ No ☐
Root Canal/Therapy/Treatment _____Yes ☐ No ☐ Cosmetic Dentistry _____ Yes ☐ No ☐

Do you have any pain when chewing? _____ Yes ☐ No ☐

Are you aware if you grind or clench your jaw? _____ Yes ☐ No ☐

Do you have difficulty opening or closing your jaw?_____ Yes ☐ No ☐

Do you hear clicking/popping sounds when chewing? _____ Yes ☐ No ☐

Are there any sore spots in your mouth?_____ Yes ☐ No ☐

Are your gums swollen or tender? _____ Yes ☐ No ☐

Do your gums bleed when eating brushing or flossing? _____ Yes ☐ No ☐

Have you ever been diagnosed or treatment for periodontal (gum) disease? _____ Yes ☐ No ☐

Do experience bad breath? _____ Yes ☐ No ☐

Are you aware of any loose teeth? _____ Yes ☐ No ☐

How often do you brush? _____ Floss?_____ Other products? _____

Are you happy with the appearance of your teeth? (colour, shape, position)_____

_____

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative ☐ Dental office ☐ yellow pages

☐ Newspaper ☐ Website ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

I understand the above information is necessary to provide me with dental care in a safe efficient manner. I have answered all the questions to the best of my knowledge. Should further information be needed, you have my permission to ask the representative health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medications.

Signature _____ **Date** _____/_____/_____