Grand Avenue Dental, LLC
960 Grand Avenue
St. Paul, MN 55105
651-291-9667

Chart # __________________ (office use only)

Patient Name: (First) ____________________ (MI) ___ (Last) ____________________ (Preferred Name) _________________
Gender: M / F Family Status: Married / Single / Child / Other
Birth Date: ________________ E-Mail Address: _________________________________
Phone: (H) __________________ (W) __________________ , ext ____ (C) ___________________
Address: ____
Address: (City) ______________________________ (State) _____ (Zip) __________________

DENTAL HISTORY

WRITE IN OR CIRCLE THE APPROPRIATE ANSWER Yes (Y) or No (N)
Previous Dentist Name: ____
Date of last exam: ____

1. Do your gums bleed while brushing or flossing? Y / N
2. Are your teeth sensitive to hot or cold liquids or foods? Y / N
3. Are your teeth sensitive to sweet or sour liquids or foods? Y / N
4. Do you associate pain with any of your teeth? Y / N
5. Do you have any sores or lumps in or near your mouth? Y / N
6. Have you had any head, neck or jaw injuries? Y / N
7. Have you experienced any of the following problems in your jaw?
   a. Clicking Y / N
   b. Pain (joint, ear, side of face) Y / N
   c. Difficulty in opening or closing Y / N
   d. Difficulty in chewing Y / N
8. Do you have frequent headaches? Y / N
9. Do you clench or grind your teeth? Y / N
10. Do you bite your lips or cheeks frequently? Y / N
11. Have you ever had any difficult extractions in the past? Y / N
12. Have you ever had any prolonged bleeding following extractions? Y / N
13. Have you had any orthodontic treatment? Y / N
14. Do you wear dentures or partials? Y / N
    a. If yes, date of placement? _______________
15. Have you ever received oral hygiene instructions? Y / N
16. Do you like your smile? Y / N