Time 10:31 AM | Harper College | Date 11/2/2021

Dental Profile II

Patient Name: | Birth Date: | Date Created:

Please tell us about your dental experience since the last time we saw you in our clinic.

General Questions

Has there been any changes in the name or address of your primary dentist? If yes, please include new information.	◯ Yes ◯ No	If yes	
Have you seen a dentist since your last visit in our clinic? If yes, what did you see the dentist for?	◯ Yes ◯ No	If yes	
Are you experiencing any tenderness, discomfort or soreness with your teeth, gums, or any area of your mouth?	◯ Yes ◯ No	If yes	
Do you have any concerns regarding your dental health? If yes, what are your concerns?	◯ Yes ◯ No	If yes	

Do you have any of the following oral habits?

Grinding your teeth ◯ Yes ◯ No	Clenching your teeth ◯ Yes ◯ No	Chewing on pens/pencils ◯ Yes ◯ No	Biting fingernails ◯ Yes ◯ No
Chewing on lips or cheeks ◯ Yes ◯ No	Other ◯ Yes ◯ No		

Please check the types of snacks you typically eat in a day.

Candy/mints	☐	If yes	
Cough drops	☐	If yes	
Cakes/pies/doughnuts	☐	If yes	
Pop/soda/fruit drinks	☐	If yes	
Energy drinks	☐	If yes	
Jellies/jams/syrup/dried fruit	☐	If yes	
Other	☐	If yes	

Signatures

Signature of Patient, Parent or Guardian:

X Date:_____

Signature of Student Dental Hygieist:

X Date:_____