DENTAL HISTORY

What is the reason for your visit today? _____
_____

Date of last dental visit _____last dental cleaning _____ last full mouth x-rays _____
What was done at your last dental visit? _____
_____
Previous dentist name _____
Address _____

How often do you have dental examinations? _____
How often do you brush your teeth? _____ How often do you floss? _____
Do you use other dental aids? (electric toothbrush, toothpick, etc.) _____
If you have any dental problems now please describe. _____
_____
_____

Check any of the following conditions that apply to you.

- ☐ Tooth pain?
- ☐ Teeth sensitive to hot or cold?
- ☐ Teeth sensitive to sweets?
- ☐ Mouth odors or bad tastes?
- ☐ Cold sores, blisters, etc.?
- ☐ Gums bleed or hurt?
- ☐ Parents had gum disease?
- ☐ Loose teeth or change in bite?
- ☐ Food caught between teeth?
- ☐ Orthodontic treatment?
- ☐ Oral surgery/ extractions?
- ☐ Periodontal treatment?
- ☐ Dentures or partials?
- ☐ Teeth ground or bite adjusted?
- ☐ Bite plate or mouth guard?
- ☐ Clicking or popping of jaw?
- ☐ Pain in joint, ear, side of face?
- ☐ Difficulty chewing?
- ☐ Tired jaws, especially in the morning?
- ☐ Difficulty opening or closing mouth?
- ☐ Frequent headaches?
- ☐ Clenching or grinding teeth?
- ☐ Head, neck or jaw injury?
- ☐ Nervous about dental treatment?
- ☐ Desire to change smile?
- ☐ Desire whiter teeth?

Is there anything else about dental treatment that you would like us to know?
_____
_____
_____

X

Signature of Patient (or Parent/Guardian, if minor) **Date**