Dental History

What is the reason for your visit today? _____

Date of last dental visit? _____ Dental Cleaning? _____ Dental x-rays? _____

Previous dentist's name _____ Location _____

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? Yes, No Such as? _____

Are your teeth sensitive to hot or cold? _____ Sweets? _____ Biting? _____

If yes, where? _____

Does food constantly wedge between any teeth? Yes No If yes, Where? _____

Do your gums ever bleed or feel tender?	Yes	No
Do any of your teeth feel lose?	Yes	No
Are you aware of clenching or grinding your teeth?	Yes	No

Have you ever had:

Orthodontic treatment (braces)?	Yes	No
Wisdom teeth removed?	Yes	No
Periodontal (gum) treatment?	Yes	No
A biteplate or nightguard?	Yes	No
Clicking/popping of jaw?	Yes	No
Pain/discomfort in jaw joint (TMJ)?	Yes	No
Difficult in opening or closing the mouth?	Yes	No
A serious jaw or head injury?	Yes	No
A reaction to "Novocain"?	Yes	No

Are you satisfied with your teeth's appearance?	Yes	No
Are you interested in keeping your natural teeth?	Yes	No
Have you had a previous upsetting dental experience?	Yes	No

If yes, please describe. _____

Is there anything that you would like us to know about having dental treatment performed?

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