Dental History

Name____ Date of Birth___________

Reason for this visit____

When was your last dental visit____________________ What was done then__________________________________

How often did you visit the dentist in the past____

Previous dentist (name/address/phone)____

Have you had recent dental x-rays taken_________________ If so, where___________________________________

How often do you brush your teeth_____________________ How often do you floss__________________________

Is your drinking water fluoridated_______________ Did you ever wear braces__________________________________

	Yes	No
Do your gums bleed when you floss?.....	[ ]	[ ]
Any sensitivity to hot or cold ?...............	[ ]	[ ]
Any sensitivity to sweet or sour?............	[ ]	[ ]
Do you feel pain in any of your teeth?	[ ]	[ ]
Any sores or lumps in/near your mouth?	[ ]	[ ]
Any trauma to your head/neck/jaws?.....	[ ]	[ ]
Any dentures or partials?.........................	[ ]	[ ]
Do you clench or grind your teeth?..........	[ ]	[ ]
Any of the following with your jaws?		
Clicking...	[ ]	[ ]
Joint pain..	[ ]	[ ]
Any difficulty opening or closing...	[ ]	[ ]
Any difficulty chewing....................	[ ]	[ ]

	Yes	No
Do you bite your lips or cheeks?............................	[ ]	[ ]
Any of your teeth loose?.......................................	[ ]	[ ]
Does food get caught between your teeth?............	[ ]	[ ]
Have you ever had gum treatment/surgery?..........	[ ]	[ ]
Ever worn a bite guard?..	[ ]	[ ]
Any prolonged bleeding following extractions?......	[ ]	[ ]
Do you use an electric toothbrush?........................	[ ]	[ ]
Do you have frequent headaches?.........................	[ ]	[ ]

If you could change your smile, what would you change?

Patient Signature____ Date______________________

Doctor Comments

Signature____ Date_____________________