Dental History **Name:**_____

Date of Last Dental Visit:_____ Date of Last Cleaning:_____

What was done at your last dental visit?_____

Previous Dentist's Name:_____

Address:_____ Phone: _____

How often do you have dental examinations?_____

How often do you brush your teeth?_____

How often do you floss your teeth? _____

What type of toothbrush do you use? Soft Medium Hard Electric

What type of toothpaste do you use? Tartar Control Sensitivity Whitening Fluoride

Do you use any other dental aids or rinses? _____

Do you have any dental problems or concerns now? Yes No

If yes, please describe: _____

Are you satisfied with the appearance of your teeth? Yes No

If no, what would you like to change? _____

Are any of your teeth sensitive to:

Hot or cold?	Y	N
Sweets?	Y	N
Biting or Chewing?	Y	N

Have you been told that you have gum disease?	**Y**	**N**
Do your gums bleed or hurt?	Y	N
Have you noticed bad breath or mouth odor?	Y	N
Have you noticed loose teeth / change in your bite?	Y	N
Have your parents have gum disease or tooth loss?	Y	N
Does food "pack" in between teeth?	Y	N

If yes, where?_____

Do you:

Clench or grind your teeth?	Y	N
Bite your cheeks or lips regularly?	Y	N
Hold foreign objects with your teeth (nails, pins)?	Y	N
Breathe through your mouth?	Y	N
Have tired / sore jaw muscles especially in the am?	Y	N
Smoke / Chew tobacco?	Y	N

Have you ever had:

Orthodontic treatment (braces)?	Y	N
Retainers?	Y	N
Oral Surgery?	Y	N
Periodontal Treatment?	Y	N
Bite adjustment?	Y	N
Bite plate or mouth guard?	Y	N
Dentures / Partials?	Y	N
Serious injury to mouth or head?	Y	N

If yes, please describe:_____

_____

Have you experienced:

Clicking or popping of the jaw?	Y	N
Pain in your jaw joint?	Y	N
Difficulty opening or closing?	Y	N
Difficulty chewing?	Y	N
Headaches, neck aches, or shoulder aches?	Y	N

Do you feel anxious about receiving dental treatment?	Y	N

If yes, what is your biggest concern?_____

Have you ever had an upsetting dental experience?	Y	N

If yes, please describe_____

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