DENTAL HISTORY

Patient's Name:_____

Previous Dentist: _____
Last dental exam: _____

How often do you have your teeth cleaned? 3mo 4mo 6mo 1 yr or longer

How often do you brush your teeth?_____ Floss?_____

What is your immediate concern?_____
_____
_____

Do you have any teeth that are sensitive: YES NO
If yes please explain:_____
_____
_____

Does dental treatment make you nervous or anxious? YES NO
If so how can we make it easier for you?_____
_____

Have you ever seen a periodontist (gum specialist)? YES NO

Have you ever had braces? YES NO When:_____

Have you ever had your bite adjusted? YES NO

Do you grind your teeth? YES NO Have you ever had a night guard?___

Do you get frequent headaches? YES NO Migraines? YES NO

Does your jaw pop or click when you open or close? YES NO

Are you happy with the appearance of your teeth? YES NO
If not what changes would you like to make?_____
_____
_____

Signature:_____ Date:_____