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DENTAL HISTORY

Name _____ Date of Birth _____

What is the reason for your visit today? _____

Date of last dental visit _____ Date of last dental cleaning _____

Date of last dental x-rays _____ Type of x-rays taken _____

Do you have any dental problems now? Yes No If yes, please explain:

Does dental treatment make you nervous? ___No ___Slightly ___Moderately ___Very

Is there anything else you would like us to know about your mouth, your teeth or your smile?

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

Are your teeth sensitive to:	Yes	No	Have you ever had:	Yes	No
Hot or cold?			Orthodontic treatment?		
Sweets?			Oral Surgery?		
Biting or chewing?			Periodontal treatment?		
Do your gums bleed or hurt?			Your teeth ground or the bite adjusted?		
Do you frequently get cold sores, blisters or other oral lesions?			A night guard or brux guard?		
			A serious injury to the mouth or head?		
Have you noticed any loose teeth or change in your bite?			Have you ever experienced:	Yes	No
			Clicking or popping of the jaw?		
Does food tend to become caught in between your teeth?			TMJ pain?		
			Difficulty opening or closing the mouth?		
Do you:	Yes	No	Headaches, neck, or shoulder aches?		
Clench or grind your teeth?			Do you smoke or use tobacco?		
Bite your lips or cheeks often?			Have you ever had an upsetting dental experience?		
Hold foreign objects with your teeth? (pencils, nails, etc.)			Are you satisfied with your teeth's appearance?		
Use a CPAP machine?					