DENTAL HISTORY

NAME ______________________ BIRTH DATE ______________ TODAY'S DATE ______________

PHONE # (HOME) ______________ (CELL) ______________ (WORK) ______________

1. Reason for visit: ______________________________
2. When was your last dental exam? ______________________________
3. How often do you brush your teeth? ______________________________
4. What texture brush do you use? ☐ Soft ☐ Medium ☐ Hard

	YES	NO
5. Are you aware of any broken teeth or broken fillings?	☐	☐
6. Do your gums bleed while brushing or flossing?	☐	☐
7. Do you feel pain in any of your teeth while brushing or flossing?	☐	☐
8. Are your teeth sensitive to hot, cold, sweet or sour foods/liquids?	☐	☐
9. Have you noticed any loosening of your teeth?	☐	☐
10. Does food tend to become caught between your teeth?	☐	☐
11. Do you have any sores or lumps in or near your mouth?	☐	☐
12. Have you ever experienced any of the following problems in your jaw?		
a. Clicking?	☐	☐
b. Pain (joint, ear, side of face)?	☐	☐
c. Difficulty in opening or closing?	☐	☐
d. Difficulty in chewing?	☐	☐
13. Do you have sinus pain or pressure?	☐	☐
14. Do you snore?	☐	☐
15. Have you had any head, neck, or jaw injuries?	☐	☐
16. Do you have frequent headaches?	☐	☐
17. Do you clench or grind your teeth while awake or asleep?	☐	☐
18. Do you bite your lips or cheeks frequently?	☐	☐
19. Do you suffer from dry mouth?	☐	☐
20. Have you ever had:	☐	☐
a. Orthodontic Treatment (braces)?	☐	☐
b. Oral Surgery?	☐	☐
c. Gum Treatment?	☐	☐
d. Your teeth ground or the bite adjusted?	☐	☐
e. Worn a bite plane or other appliance?	☐	☐
21. Are you satisfied with the appearance of your teeth?	☐	☐
If no, please explain: ______________________________		
22. Have you ever had an upsetting experience in the dental office?	☐	☐
23. Is there anything about having dental treatment that bothers you?	☐	☐
If yes, please explain: ______________________________		