DENTAL HISTORY

Patient Name ___________________

Today's Date ___________________

What is the reason for today's visit? ____

When was your last dental Visit? _____________

Did you have X-Rays taken at that time? Yes/No

When was your last dental cleaning? _______________________________

Have you ever been told that you have gum disease? Yes/No if yes, have you ever been treated for gum disease? (*please explain*) ____

How often do you brush your teeth? __________________ Floss? ______________________

Do you use an electric toothbrush? Yes/No

Are you happy with your smile? Yes/No (*if no, please explain*)______________________________

Would you like to have whiter teeth? Yes/No

Are you interested in straightening your teeth? Yes/No

1. Have you ever had orthodontic treatment? Yes/No
2. Do you wear a retainer? Yes/No

Do you snore or have sleep apnea? Yes/No If yes, do you wear a C-Pap machine? Yes/No

Do you clench or grind your teeth? Yes/No Explain: ____________________________________

Clicking /popping jaw? Yes/No Jaw pain/pain around ears? Yes/No

Please circle all that apply

bad breath	frequent headaches or migraines
bleeding gums	mouth sores/ulcers
swollen or tender gums	gum recession
blisters on lips/mouth	mouth breathing
burning sensation in mouth/tongue	unpleasant taste or odor
metallic taste	sensitive to hot/cold