# DENTAL HISTORY

**(Patient's) First Name**_____ **Last Name** _____ **Date of Birth**_____

What is the purpose of your visit today? _____

When were you last at the dentist? _____

When was the last time your teeth were cleaned? _____

Do you make regular visits to the Dentist? .....Yes No If Yes, how often? _____

Do you have a problem with any teeth? .....Yes No

If Yes, circle one or more Area(s) TOP RIGHT TOP FRONT TOP LEFT

BOTTOM RIGHT BOTTOM FRONT BOTTOM LEFT

Are you missing any teeth? .....Yes No If Yes, were they replaced? YES NO

Do you have crooked teeth or is your "bite off" .....Yes No

Have you ever had Braces or Invisalign before? .....Yes No

Have you been diagnosed with gum disease before? .....Yes No

Have you ever had "deep cleanings" before? .....Yes No

Do you have any broken or chipped teeth? .....Yes No

Do you have any loose teeth? .....Yes No

Are you unhappy with the appearance of your teeth? .....Yes No

Do you clench or grind your teeth during the day or overnight? .....Yes No If Yes, Do you wear a guard? YES NO

Does your jaw click or pop? .....Yes No

Do you have facial pain or jaw muscle pain? .....Yes No

Are you sensitive to any of the following? (circle them) HOT COLD SWEETS PRESSURE CHEWING

How often do you brush your teeth? _____

How often do you floss your teeth? _____

Do your gums ever bleed? .....Yes No If Yes, When? _____

Do you snore at night? .....Yes No

Do you have anxiety related to dentistry in any way, shape or form? ..... Yes No

Have you had problems with previous dental treatment? .....Yes No

If Yes, tell us here if you would like _____

Do you have any special requests regarding your visits or how we can make you comfortable? .....Yes No

If Yes, tell us here _____

**I certify that the above information is complete and accurate**

**Patient's Signature** _____ **Date** _____

**Dentist's Signature** _____ **Date** _____