DENTAL HISTORY

Patient name: _____ DOB: _____

What is reason for your visit today?

_____

Previous Dentist: _____

Previous Dentist Address: _____

Previous Dentist Phone: _____

Last dental exam: _____ Last dental cleaning: _____

Last full mouth xrays: _____

How often do you brush? _____ How often do you floss? _____

Other dental aids used? _____

Are you having any problems currently? YES NO

If yes, please describe:

_____

Please indicate by circling which of the following you have had, or have at present:

Sensitivity to hot or cold	Bleeding gums	Cold sores/ulcers
Clenching/grinding	Sensitivity to biting/chewing	Painful gums
Bad tastes/odors	Tired jaw muscles	Sensitivity to sweets
Loose teeth	Food packs between teeth	Clicking/popping of jaw
Orthodontic treatment	Periodontal treatment	Oral Surgery
Difficulty in opening/closing	Difficulty in chewing	Headaches/neckaches
Pain with ear/jaw joint	Smoking tobacco/use	

Comments regarding any above conditions:

_____

_____

Have you ever had an upsetting experience with dental treatment? YES NO

If yes, please explain:

_____

_____

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

_____

Patient/Guardian Signature: _____ Date: _____