DENTAL HISTORY: Name: _____Date: _____

When was your last dental appointment? _____
Previous/Present dentists name: _____
City, State, Phone: _____
Main reason for your visit? _____

When was your last dental cleaning? _____
Dental X-Rays? _____
Have you ever been told or treated for gum disease? Yes No
Did you receive non-surgical therapy? Yes No
Have you had gum surgery? Yes No
When was your gum disease treated? _____
Are your teeth sensitive to: (Please Circle)
Heat? Yes No Cold? Yes No Sweets? Yes No Biting? Yes No
Do you notice: (Please Circle)
Bleeding upon brushing or flossing? Yes No Gums receding? Yes No
Gums swelling around your teeth? Yes No Bad breath/Taste? Yes No
Have you ever experienced: (Please Circle)
Discomfort, popping, or locking of your jaw? Yes No
Pain upon chewing, opening wide or yawning? Yes No
Grinding or clenching your teeth? Yes No
Frequent headaches, neck or shoulder aches? Yes No
Loose teeth or changes in your bite? Yes No
Do you have a night guard? Yes No
Do you wear it? Yes No

How important is your dental health to you: (Please Circle)
Very important Not important
On a scale of 1-10 (10 being the best) how would you rate your:
Dental Health: _____ Your Smile: _____
Would you like your teeth to be: (Please Circle)
Whiter? Yes No Straighter? Yes No Have you had braces? Yes No
Are there any old silver-mercury fillings or dental work that you don't like the appearance or feel of? Yes No Please Specify: _____
_____
Do you have any dental fears or anxieties? Yes No Please Specify: _____
_____

Do you want nitrous oxide (laughing gas)? Yes No Oral sedation? Yes No
What can we do to make your visit more comfortable? _____
_____