Patient Name:

# Dental History

What is the reason for your visit today?________________________________________________

Date of last dental visit:__________________________Last dental cleaning:_________________________________

How often do you have dental examinations?____________________________________________

How often do you brush your teeth?_____________________How often do you floss?_________________________

What other dental aids do you use?(waterpik, toothpick, etc.)_______________________________________________

Do you have any dental concerns now?_________________________________________________

**Are any of your teeth sensitive to:**

hot cold sweets chewing

**Have you noticed any:**

bad odors bad tastes bleeding gums change in bite cold sores fever blisters

**Does food become caught between your teeth?** Yes No

If yes where?_____________________________________________________________

**Do you:**

clench/grind bite lips/cheeks mouth breathe have tired jaws (AM) snore have sleep apnea

smoke/chew tobacco or other:__________________________________________________

**Have you ever had:**

orthodontic treatment oral surgery periodontal treatment injury to mouth/head

**Have you experienced:**

clicking/popping of jaw difficulty opening/closing pain in joint/ear/side of face

**Do you feel nervous about dental treatment?** Yes No

If yes please explain:_______________________________________________________

**Have you had an upsetting dental experience?** Yes No

If yes please explain:_______________________________________________________

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

_____________________________________________________________________________