



Dental History

Patient Name _____ Date of Birth _____

Date of most recent dental exam (if known) _____ Date of most recent dental x-rays (if known) _____

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

How often do you drink pop/energy drinks/sugared beverages? _____

- Y N Do you have sensitive teeth?
 Hot Cold Sweets Pressure/chewing
- Y N Have you ever been treated for periodontal disease (gum disease)?
- Y N Do your gums bleed when you brush/floss/chew?
- Y N Do you have any loose teeth?
- Y N Are you aware of any swelling or lumps in your mouth?
- Y N Have you had orthodontics (braces)?
- Y N Do you wear a removable retainer or night guard?
- Y N Have you had your wisdom teeth removed?
- Y N Do you clench or grind your teeth?
- Y N Do you experience jaw pain/soreness/clicking/popping?
- Y N Is there anything about the appearance of your teeth that you would like to change?
- Y N Are you interested in tooth whitening?
- Y N Are you fearful of dental treatment?
- Y N Have you had an unfavorable dental experience?
- Y N Have you ever had trouble getting numb or had any reactions to local anesthetic?

Is there anything else you would like us to know? _____

Patient signature _____

Date _____