DENTAL HISTORY

For the following questions, please mark (X) your responses to the following questions.

Name:_____

	Yes	No
Are you currently experiencing dental pain or discomfort?	❑	❑
Do your gums bleed when you brush or floss?	❑	❑
Are your teeth sensitive to cold, hot, sweets or pressure?	❑	❑
Does food or floss catch between your teeth?	❑	❑
Is your mouth dry?	❑	❑
Have you had any periodontal (gum) treatments?	❑	❑
Have you ever had orthodontic (braces) treatment?	❑	❑
Is your home water supply fluoridated?	❑	❑

What is your reason for your visit today?_____

_____

_____

How do you feel about your smile? _____

_____

_____

	Yes	No
Do you have earaches or neck pains?	❑	❑
Do you have any clicking, popping or discomfort in the jaw?	❑	❑

	Yes	No
Do you clench or grind your teeth?	❑	❑
Do you have sores or ulcers in your mouth?	❑	❑
Do you wear dentures or partials?	❑	❑

How many partials/dentures have you had? _____

When was your last partial/denture made? _____

Have you ever had a serious injury to your head or mouth? ❑ ❑

_____

_____

Have you had any problems associated with previous dental treatment? ❑ ❑

_____

_____

Date of your last dental exam: _____

What was done at that time? _____

_____

Date of last dental x-rays: _____

Signature _____ Date_____