DENTAL HISTORY

PATIENT NAME ____ BIRTH DATE __________________

1. What is the reason for your visit today?
   ____
   ____
   ____

2. Previous Dental Provider information:
   a. Last Dental Visit Date___________ Last Dental Cleaning Date__________ Last Xrays Date__________
   b. What was done at your last dental visit?____
   c. Previous Dentist's Name____
      i. Address____
      ii. Phone Number:____
   d. How often do you have dental examinations?________________________________
   e. How often do you brush?_______ floss?_______
   f. What other dental aids do you use (i.e. electric toothbrush, toothpick, etc)?_____________________________

3. Current Dental Conditions/Concerns:
   a. Sensitivity Yes No
   b. Clenching Yes No
   c. Grinding Yes No
   d. Mouth or breath odors Yes No
   e. Oral lesions Yes No
   f. Lumps or bumps Yes No
   g. Clicking or popping in your Jaw Yes No
   h. Jaw/ Facial Muscle Pain Yes No If yes, explain:____________________________________
   i. Mouthguard, retainers, or other oral appliance Yes No If yes, explain:_________________________________
   j. Existing cracks, chips, fractures, or broken teeth? Yes No If yes, explain:______________________________
   k. History of:
      Orthodontics Yes No
      Periodontics Yes No
      Oral surgery Yes No
      Serious injury to your mouth or head Yes No If yes, explain:__________________________________

4. If you could improve your smile, what do you want to be different (i.e. spaces, crowding, whiter, straighter, etc)?
   ____
   ____
   ____

5. Please describe anything about your dental health or having dental treatment that you would like us to know (including past negative experiences, immediate dental issues or concerns, individual special considerations)?
   ____
   ____
   ____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can Be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in my dental status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ____ DATE ___________________