DENTAL HISTORY

Patient Name:_____
Reason for visit today:_____
Former dentist:_____
City/State:_____ Phone:_____
Date of last dental visit:_____ Reason for last visit:_____
Date of last x-rays:_____
How often do you have dental examinations?_____

Please circle 'Y' or 'N' for the following questions and add any comments regarding the condition:

Do you have bad breath…Y N	
Do your gums bleed when brushing/flossing…Y N	
Does your tongue burn...Y N	
Do you chew on one side of mouth…Y N	
Does your jaw click or pop…Y N	
Do you have jaw pain…Y N	
Do you have dry mouth…Y N	
Do you bite your fingernails…Y N	
Do you hold foreign objects between teeth…Y N	
Does food collect between teeth…Y N	
Do you grind your teeth…Y N	
Do you wear a night guard…Y N	
Do you bite your lips/cheeks…Y N	
Do you have loose teeth…Y N	
Do you have broken teeth or fillings…Y N	
Are you a mouth breather…Y N	
Do you have cold sensitivity…Y N	
Do you have hot sensitivity…Y N	
Do you have sweet sensitivity…Y N	
Do you have biting sensitivity…Y N	
Do you have sores/growths in mouth…Y N	
Have you used Nitrous Oxide…Y N	
Would you like Nitrous Oxide…Y N	
Would you like whiter teeth…Y N	
Do you have frequent headaches…Y N	
Have you had orthodontic treatment…Y N	If yes, when
Have you had periodontal treatment…Y N	If yes, when
Have you had previous extractions…Y N	If yes, when
How often do you brush?	
How often do you floss?	
Is there anything you wish you could change about your smile?	