DENTAL HISTORY

Patient Name: _____ Date: _____

Have you ever had any serious trouble associated with previous dental treatment? □ Yes (please explain) □ No

_____

_____

Does dental treatment make you nervous? □ No □ Slightly □ Moderately □ Extremely

Date of last dental visit: _____

Have you ever been treated for periodontal disease (gum disease)? _____

If so, when? _____

Do you have or have you ever had any of the following? (check all that apply)

□ Bleeding, sore gums	□ Unpleasant taste/bad breath	□ Burning tongue/lips
□ Frequent blisters	□ Swelling/lumps in mouth	□ Orthodontic treatment (braces)
□ Biting cheeks/lips	□ Clicking/popping jaw	□ Difficulty opening or closing jaw
□ Loose teeth	□ Sensitivity to hot/cold	□ Sensitivity to biting/chewing
□ Sensitivity to sweets	□ Food impaction	□ Clenching/grinding
□ Shifting of teeth	□ Change in bite	□ Whitening of teeth

How often do you do the following?

Brush: _____ Floss _____ Rinse _____

Is there anything about your smile that you would like to improve? _____

_____