

## DENTAL HISTORY

What is your main concern about your teeth? \_\_\_\_\_

\_\_\_\_\_

If you could change anything about your teeth, what would it be? \_\_\_\_\_

\_\_\_\_\_

Are you interested in whitening your teeth? Yes or No

When was your last visit to the dentist? \_\_\_\_\_

What was done at that time? \_\_\_\_\_

How often do you have your teeth professionally cleaned? \_\_\_\_\_

Do you floss? Yes or No How often? \_\_\_\_\_

What kind of toothbrush do you use? Manual or Electric

Do your gums bleed either in chewing, brushing or at any other time? Yes or No

Explain: \_\_\_\_\_

Have your gums ever been treated? Yes or No If yes, when? \_\_\_\_\_

Do you have pain or soreness in your teeth or gums? Yes or No

Does food catch between your teeth? Yes or No If yes, where? \_\_\_\_\_

Are and of your teeth sensitive to sweets? Yes or No

Are and of your teeth sensitive to temperature? Yes or No

Are and of your teeth sensitive to Pressure? Yes or No

Do you suffer from any headaches or migraines on a regular basis? Yes or No

Do you notice popping or clicking in your jaw when you open or close? Yes or No

Do you clench or grind your teeth? Yes or No

Do you have a tired feeling in your face while chewing or any particular time during the day? Yes or No

Have you had any wisdom teeth removed? Yes or No

Have you had any teeth removed? Yes or No

If yes, are you interested in replacing any missing teeth? Yes or No

Have you had orthodontic treatment? Yes or No

Patient Name: \_\_\_\_\_

(Signature)

(Please Print Name)

Date: \_\_\_\_\_

Reviewed by: \_\_\_\_\_