Dental History

Name_____ **Date**_____

1. What services are you seeking?_____

_____

2. How would you describe your past dental experiences? Good Fair Poor

Yes No **3.** Do you have difficulties with injections?

4. When was your last dental appointment? _____

5. What services were performed?_____

6. How long has it been since you had a thorough evaluation of your mouth? _____
a. Teeth cleaned? _____ **b.** X-rays of your entire mouth? _____

Yes No **7.** Do you regularly consume foods or beverages with high sugar content?

Yes No **8.** Are you prone to cavities?

Yes No **9.** Do you or anyone in your family wear removable dental appliances?

10. How often do you brush?_____ **11.** How often do you floss? _____

Yes No **12.** Do your gums bleed?

Yes No **13.** Have you been treated for gum disease?

Yes No **14.** Do you have lumps or sores in your mouth?

Yes No **15.** Do your teeth feel uncomfortable or sore when you bite or chew

Yes No **16.** Are your teeth sensitive to hot, cold or sweets?

Yes No **17.** Do you clench or grind your teeth?

Yes No **18.** Have your ever had or been treated for TMJ or jaw joint problems?

Yes No **19.** Do you have frequent headaches or pain in your face?

Yes No **20.** Have you ever worn braces? When?_____

Yes No **21.** Do you have missing teeth?

Yes No **22.** Have you had extensive dental treatment in the past?

Yes No **23.** Do you like your smile?

24. Is there anything else that you feel we should know about your mouth?

_____

Signature_____ Assistant_____