Dental History Form

1. What is the reason for your visit today? _____
2. When was the last time you saw a dentist? _____
3. What was done at that time? _____
4. Have you ever been treated for periodontal disease (gum disease)? Yes No
5. Have you had orthodontic treatment (braces)? Yes No
6. Do you snore? Yes No
7. Does dental treatment make you nervous? Yes No
8. Have you ever had an unpleasant dental experience? Yes No
   If yes, explain: _____
9. Do you experience any of the following? Yes No

Bleeding or sore gums	Yes	No	Loose teeth	Yes	No
Bad breath/unpleasant taste	Yes	No	Sensitive to hot	Yes	No
Frequent dry mouth	Yes	No	Sensitive to cold	Yes	No
Tingling or burning tongue or lips	Yes	No	Sensitive to sweets	Yes	No
Swelling or lumps in mouth	Yes	No	Clicking/popping jaw	Yes	No
Sores in mouth	Yes	No	Frequent headaches	Yes	No
Food trapping between teeth	Yes	No	Grinding/clenching	Yes	No

10. How often do you brush your teeth? _____
11. Do you use dental floss or tape? _____ How often? _____
12. What type of toothbrush do you use (circle) Soft Medium Hard Electric
13. What other cleaning aids, devices, or rinses do you use? _____

Smile Evaluation

1. Are you self conscious when you smile in front of other people or pictures? Yes No
2. Do you ever cover your smile with your hand? Yes No
3. Do you with your teeth were whiter? Yes No
4. Do you dislike the shape of your teeth? Yes No
5. Do you have spaces between your teeth that you don't like? Yes No
6. Do you have old fillings or dental work that you don't like looking at? Yes No
7. If you could wave a "magic wand" and change the appearance of your smile, how would you like to look? _____

Please list any questions and concerns that you may have about your mouth or oral health:

_____

Date: _____ Signature: _____