Patient name: ____ # Dental History form

All information is confidential

What is the reason for your visit today?		
Date of your last dental visit:	Date of last dental cleaning:	Date of last x-rays:
Your dentist name and phone number		
How often do you have dental check up/cleaning?		
How often do you brush your teeth?	Floss your teeth?	
What other dental aids do you use?		

Do you:

Have any dental problem, pain, or sensitivity now? If yes, please describe:	Yes	No
Feel nervous about having dental treatment? If yes, what is your biggest concern:	Yes	No
Clench or grind your teeth while awake or sleep?	Yes	No
Breath through your mouth?	Yes	No
Have a tired jaw, especially in the morning?	Yes	No
Chew tobacco?	Yes	No

Have you ever had:

An upsetting dental experience?	Yes	No
Orthodontic treatment?	yes	No
Periodontal (gum) surgery?	Yes	No
Oral surgery?	Yes	No
Facial joint pain?	Yes	No
Difficulty opening and closing you mouth?	Yes	No
Clicking or popping of jaw?	Yes	No
Dry mouth?	Yes	No
Mouth odor or bad taste?	Yes	No
Dry mouth?	Yes	No
Food caught in or between your teeth?	Yes	No

Please answer the following

Would you like to improve the appearance of your teeth?	Yes	No
Would you like to have whiter teeth?	Yes	No
Is there anything else about your dental condition that you would like us to know? If so, please describe here:	Yes	No

Patient's/guardian signature ____ **Date** ____________