Today's Date:

DENTAL HISTORY

The main reason you are here today is:

_____

Name and location of previous dentist:

_____

Date of last dental exam: _____ *Date of last x-rays:* _____

	YES	NO
1. Do your gums bleed when brushing and/or flossing?	□	□
2. Are your teeth sensitive to hot/cold liquids or foods?	□	□
3. Are your teeth sensitive to sweet/sour liquids or foods?	□	□
4. Do you feel pain in any of your teeth? If yes where?_____	□	□
5. Do you have or have you had any sores or lumps in or around your mouth?	□	□
6. Have you ever had any head, neck, or jaw injuries?	□	□
7. Does your jaw click or hurt when you open and close?	□	□
8. Do you have frequent headaches in the morning?	□	□
9. Do you clench or grind your teeth?	□	□
10. Do you bite your cheeks or lips frequently?	□	□
11. Have you ever had any difficult extractions in the past?	□	□
12. Have you ever had any prolonged bleeding following extractions or dental treatment?	□	□
13. Have you had any orthodontic treatment? If yes, when?_____ If no are you interested?_____	□	□
14. Do you wear dentures or partials? If yes, year of placement:_____	□	□
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	□	□
16. Do you have dry mouth?	□	□
17. Do you like your smile?	□	□
18. Would you be interested in whitening your teeth?	□	□

Referral Information

Whom may we thank for referring you to our practice?

□ Another Patient, Name:_____
□ Newspaper
□ Work
□ Dental Office
□ Yellow Pages
□ School (dental health presentation)
□ Insurance company
□ Other:_____