



Dental History

Name _____ Date _____
First Mi. Last

Reason for Today's Visit _____

Date of last exam _____ Date of last dental X-rays _____

How often do you brush? _____

What type of toothbrush do you use? regular electric

How often do you floss? _____

Do you use mouthwash or some other type of rinse? Yes No Describe _____

Do you have any dental problems now? Yes No Describe _____

Have you ever had an upsetting dental experience? Yes No Describe _____

Have you ever had: Orthodontics Periodontal Surgery Oral Surgery

Please check any of the following conditions that apply to you:

- | | | |
|---|---|--|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Grinding Teeth | <input type="checkbox"/> Sensitivity to Hot |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Loose Teeth or Broken Filling | <input type="checkbox"/> Sensitivity to Cold |
| <input type="checkbox"/> Clicking or Popping jaw | <input type="checkbox"/> Periodontal Treatment | <input type="checkbox"/> Sensitivity When Biting |
| <input type="checkbox"/> Food Collection between Teeth | <input type="checkbox"/> Sores or Growths in Your Mouth | <input type="checkbox"/> Sensitivity to Sweets |
| <input type="checkbox"/> Tired jaws in the morning | <input type="checkbox"/> Sore Facial Muscles | <input type="checkbox"/> Wear a Night Guard |
| <input type="checkbox"/> Difficulty in opening or closing the mouth | | <input type="checkbox"/> Headaches or Neck Aches |

Other: _____

Previous Dentist's Name _____

Office Address _____

City _____ State _____ Zip _____

Telephone (_____) _____