

Dental History

Thank you for taking the time to complete this form. Understanding your needs help our entire dental team serve you better.

Date: _____

Name: _____

Reason for today's visit: _____

Are you currently in pain? _____

	Y	N	Comments
Have you ever experienced pain in your jaw joint (TMJ/TMD)?			
Does your jaw click?			
Are your teeth sensitive to hot and cold?			
Are your teeth sensitive to sweets?			
Have you ever worn braces?			
Have you ever had gum (periodontal) surgery?			
Have you ever had oral surgery?			
Do your gums bleed when you brush or floss?			
Do you currently use an electric toothbrush? What brand?			
Does food get caught between your teeth?			
Do you snore? Is it a problem?			
Would you like your teeth whitened?			
Do you have a chipped tooth or space that you would like corrected?			
Are you involved in sports that a mouth guard would be helpful?			
Do you have missing teeth that you would like replaced?			
Do you have a denture or partial that you do not like?			
Do you like the appearance of your teeth?			
Is there anything about your smile that you would like to change?			
Is it important to keep your teeth as long as possible?			
Are you under stress?			
Does your family have history of diabetes?			
Does your family have history of heart disease?			
Does your family have history of periodontal disease?			

Additional Comments
