DENTAL HISTORY

NAME:	DATE:
Last Dental Exam:	Last Dental X-Ray:
Last Dental Treatment:	
Last Dental Cleaning:	
What is your Immediate Dental Concern?	

PLEASE CHECK ALL ITEMS THAT APPLY:

	YES	DOCTOR'S NOTES
Unhappy with the appearance of your teeth		
Unpleasant dental experiences/dental fears		
Preference for no anesthetic		
Problems with effectiveness of Local Anesthetic		
Orthodontic treatment: Age:		
Periodontal (Gum) surgery: Date:		
Deep Cleaning/Root Planing: Date:		
Bleeding gums		
Tooth/Teeth sensitive to temperature		
Tooth/Teeth sensitive to biting		
Teeth/Gums sensitive to instruments		
Difficulty eating some or all foods		
Bad breath/Unpleasant taste in your mouth		
Jaw problems (TMJ)		
Jaw has locked open or closed		
Clench or grind your teeth		
Pain/Stiffness in the jaw or neck		
Problems with dentures or partials		
Sore or lump in mouth for more than 2 weeks		
Diagnosed with Sleep Apnea		
Snoring		
Not feeling rested after 7-8 hours of sleep		

Reasons for lost teeth (circle): DECAY GUM DISEASE KNOCKED OUT
ORTHODONTICS WISDOM TEETH

Is there anything we can do to make your visit more pleasant?

_____

Other information about your dental history or needs?

_____

_____

In the event that you need dental treatment, is there another person (e.g. spouse, parent, etc.) who is involved in decisions regarding your healthcare and/or your financial decisions? Yes_____ No_____
If yes, please give their name and relationship to you:_____

Doctor Notes: