Dental History

Name of Last Dentist _____Date of Last Exam ___/__/____

Please answer the following questions to the best of your knowledge.

Do your gums bleed when you brush or floss? □ Yes □ No
Have you noticed a bad taste or unusually bad breath? □ Yes □ No
Do you have any loose teeth? □ Yes □ No
Have you ever been diagnosed with gingivitis or periodontal disease? □ Yes □ No

Have you noticed any clicking or popping in your jaw? □ Yes □ No
Do you clench or grind your teeth? □ Yes □ No
Do you have headaches or any pain in your jaw? □ Yes □ No

Are you currently experiencing dental related pain? □ Yes □ No
Are you teeth temperature sensitive? □ Yes □ No
Are you experiencing any pain when biting or chewing? □ Yes □ No
Are any teeth sensitive to sweets? □ Yes □ No
Have you noticed any cracked, chipped, broken teeth or fillings? □ Yes □ No

Do you have, or have had any of the following? (Check all that apply)

□ Orthodontics (braces) □ Fillings □ Crowns or Caps
□ Bridges □ Implants □ Root Canal
□ Extractions

How would you rate your smile on a scale of 1-10? (10 being the best) _____
If you could change anything about your smile what would it be? _____
_____

Would you be interested in learning about whitening, invisible braces, or other cosmetic procedures? □ Yes □ No
Have you ever had a bad dental experience? □ Yes □ No