

## Dental History

How can we help you today? \_\_\_\_\_

How long since you last saw a dentist? \_\_\_\_\_, When was your last full series of X-Rays? (18 small films) \_\_\_\_\_

Have you ever worn braces?..... Yes No For how long? \_\_\_\_\_

Who was your previous dentist? \_\_\_\_\_

Why did you choose to change? \_\_\_\_\_

Rate your dental anxiety level: High Average Low None Have you ever had a bad experience in a dental office? Yes No

Please explain \_\_\_\_\_

Do you always have something to be treated or repaired when you visit a dentist?..... Yes No

Rate the sensitivity of your teeth: High Average Low None Are your teeth discolored from trauma or antibiotics? Yes No

Do you have fillings, crowns or root canals in your front teeth? Yes No Do you drink tea, coffee, red wine or sodas? Yes No

Have you used any whitening products in the past? What product and what was the result? \_\_\_\_\_

Do your gums bleed when you brush or floss?..... Yes No

Have you ever had a problem with gum disease?..... Yes No

Please explain \_\_\_\_\_

Do you have loose or shifting teeth?..... Yes No

Do you ever notice an unpleasant taste or odor in your mouth?..... Yes No

Would you like to know more about maintaining FRESH BREATH?..... Yes No

Do you ever have headaches, earaches or neck pain?..... Yes No

Where? \_\_\_\_\_ How often? \_\_\_\_\_

Are you aware of clenching or grinding your teeth when asleep or awake?..... Yes No

Have you ever had a problem with teeth or fillings breaking?..... Yes No

Have your gums receded?..... Yes No

Have you ever had trouble opening or closing your mouth or an injury to your jaw?..... Yes No

Do you ever hear a clicking or popping sound in your jaw joint?..... Yes No

Have you ever been treated for bite problems?..... Yes No

Please explain \_\_\_\_\_

Have you ever worn a nighttime grinding appliance?..... Yes No