

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 is your current general dentist? _____

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

Please explain _____

Rate the sensitivity of your teeth: High Average Low None

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

Have you ever had periodontal or gum treatment?..... 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

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