# DENTAL HISTORY

**Name**________________________________ **Date**_______________________________
**What is the reason for your visit today?**_____________________________________
**Date of last dental visit**________ **cleaning**________ **full mouth X-rays**_________
**What was done at your last dental visit?**____________________________________
**Previous Dentist Name and Address**_______________________________________
**How often do you have dental examinations?**_______________________________
**Do you have any dental problems now?** ___________________________________
**Are you wearing a partial or denture?** _____________________________________
**Are your teeth sensitive to…**Hot/Cold Biting/Chewing
**Do you have problems with..**bleeding gums, or food getting caught in teeth
____________________________________________________________________

**Have you ever had: (please circle the ones that may apply)**

Orthodontic Treatment Periodontal Treatment
Oral Surgery Other________________

**Have you ever experienced any of the following:**

Clicking or Popping of the jaw
Pain in the joint, ear, side of the face, head, neck, or shoulder
Difficulty in opening/closing mouth

**Are you satisfied with the appearance of your teeth?** **Y N**
**Are you nervous about having dental treatment?** **Y N**
**If so, what is your biggest concern?**_________________________________________
**Have you ever had an upsetting dental experience?(explain)**_________________
_____________________________________________________________________________
**This office offers I.V. Sedation would you like to know more about this? Y N**

**Would you like to know more about dental implants or any other dental treatment?**________________________________________________________________

**Is there anything you would like to change about your smile?(explain)**_______
_____________________________________________________________________________

_____________________________________________________________________________

**Signature of Patient/ Guardian**__________________________ **Date**______________