YOUR DENTAL HISTORY

Patient's Name: _____

Reason for initial visit: _____

Are you aware of any particular problems: _____

How long since your last dental visit: _____

Reason for leaving that office: _____

Previous dentist's name: _____

Are you interested in keeping your teeth as healthy as possible?	Yes	No
Have you already lost any teeth?	Yes	No
Do you cling or grind your teeth?	Yes	No
Does your jaw click or pop?	Yes	No
Does food get caught in your teeth?	Yes	No
Are any of your teeth sensitive to: Hot Cold Sweets Pressure		
Do your gums bleed or hurt?	Yes	No
How often do you brush your teeth?_____		
Do you use dental floss?	Yes	No
How Often? _____		
Are any of your teeth loose, tipped, shifted, or chipped?	Yes	No
Are you happy with the appearance of your smi	Yes	No

How do you feel about your teeth in general? _____

What did you like most about your last dentist? _____

What did you like least about your last dentist? _____

I certify that the above information is complete and accurate.

Patient's/Guardian's Signature _____

DENTAL HISTORY