Dental History Form

Patient Name: _____ **Date**: _____

1. Date of last dental visit:_____
2. How often were you seen for your cleanings? _____
3. Do you have any dental pain or concerns at the present time? **Yes or No**

   If so, where? _____ For how long? _____
4. Do you have any jaw / joint pain? **Yes or No**
5. Are you aware if you clench or grind? **Yes or No** Do you have a night guard? **Yes or No**

   Do you have any other oral habits (circle): **nail biting ice chewing other: _____**
6. Do you smoke? **Yes or No** / Chew tobacco? **Yes or No**

   How often? _____ For how long? _____
7. How often do you brush your teeth? _____ What toothpaste do you use? _____
8. Do you use mouth rinse? **Yes or No** / Which mouth rinse do you use? _____
9. How often do you floss your teeth? (circle answer) **daily occasionally never**
10. Do you have any history of the following? (circle): **Tongue/lip piercings**

    Face/jaw trauma Orthodontic work Dental implants Periodontal surgery
11. Do you suffer from dental anxiety? **Yes or No**

    Would you be interested in nitrous oxide (laughing gas): **Yes or No**
12. Do you like your smile? **Yes or No**
13. Is there anything you would like to change about your smile? (circle)

    Whiter teeth or Straighter teeth
14. What are your dental goals? (please circle one or more)

    A. Full mouth treatment / "Smile Makeover" **B. Remove all silver fillings**
    C. Treatment as needed only **D. Other_____**

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my dental health, I shall inform the dentist and staff at my next appointment.

Patient or Guardian Signature: _____ Date: _____

Reviewed by Doctor: _____ Date: _____