



Dental History

Reason for visit _____ Former Dentist/Location _____

Date of last dental visit _____ Date of last dental x-rays _____

Check to indicate if you have any of the following:

Bad Breath	0	Lip or Cheek Biting	0
Bleeding Gums	0	Loose Teeth	0
Broken Fillings	0	Mouth Breathing	0
Clicking/Popping Jaw	0	Mouth Pain	0
Dry Mouth	0	Orthodontic Treatment	0
Fingernail Biting	0	Pain Around Ear	0
Food Collection in Teeth	0	Periodontal Treatment	0
Foreign Objects	0	Sores in Mouth	0
Grinding Teeth	0	Sensitivity to Cold	0
Gums Swollen/Tender	0	Sensitivity to Heat	0
Jaw Pain or Tiredness	0	Other _____	

How often do you brush your teeth? _____

How often do you floss your teeth? _____

If you can change **anything** about your smile, what would you change?
