Val Verde
DENTAL

Dental History Questionnaire

Patient Name_____Date_____

Dates of last dental visit_____ Last dental Cleaning_____ Last dental x-rays_____

Previous dentist name _____

How often do you have a dental examination?_____

How often do you brush your teeth? _____How often do you floss? _____

Do you use any other dental aids? (Sonicare, Braun, toothpick, etc.)_____

Do you have active dental problems now?_____

If yes, please describe the problem_____

Do you have trouble with bad breath?_____ Do you have any loose teeth?_____

Have you every had:

Oral surgery or teeth removed	___ Yes	No ___
Periodontal treatment	___ Yes	No ___
Root canal therapy	___ Yes	No ___
Broken jaw	___ Yes	No ___
Missing back teeth	___ Yes	No ___
A bite splint, plate or mouth guard	___ Yes	No ___

Are any of your teeth sensitive to:

___ Hot ___ Cold ___ Sweets ____Biting or chewing

Cosmetic Analysis

If you could change one thing about your teeth or smile, what would it be?_____

_____

Have you ever had orthodontics?_____Were you pleased with the result?_____

Would you like to learn more about what orthodontic options are available?_____

Have you ever whitened your teeth?____ Were you pleased with the result?_____

Would you like to learn more about whitening options? _____

Do you have any silver fillings that you would like replace with tooth colored restorations?_____

Do you have any other questions or concerns you would like us to address?_____

_____

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