

Dental History

Patient Name _____ Today's Date _____
Birth date _____
Last First Initial

Reason for Today's Visit _____

Date of last dental care _____ Date of last cleaning _____

Previous dentist _____

Reason for leaving _____

Check (√) if you have had problems with any of the following

Bad breath	Grinding teeth	Sensitivity to hot
Bleeding or swollen gums	Loose teeth or broken fillings	Sensitivity to sweet
Clicking or popping jaw	Periodontal treatment	Sensitivity when biting
Food collection between teeth	Sensitivity to cold	Sores or growth in mouth

How often do you floss? _____ How often do you brush? _____

Do you smoke? Yes No How many per day? _____

Do you use chewing tobacco? Yes No How much per day? _____

Getting To Know You

Do you like your smile? _____ Is there anything you would change about your smile?

Do you have a preferred time of day for your dental visit? _____

Do you have any anxiety about dental treatment? Yes No

How did you hear about our office? _____