DENTAL HEALTH HISTORY

PATIENT NAME_________________________________ DATE___________________

When was your last dental visit? ____

How often did you see your former dentist? ____________________________________

Are you having any dental problems that require immediate attention? ____________________

Do any of the following cause tooth discomfort? Hot:____ Cold: ____Sweets: ___Chewing: ____

How often do you: Brush? ______ Floss? ______ Power Toothbrush? ______ Water Jet? _____

Do your gums bleed or feel tender? ____

Have you had periodontal (gum tissue) treatment? ___________ When? __________________

Do you clench or grind your teeth? ____

Have you ever had orthodontic treatment (braces)? __________ When? __________________

Do you have any missing teeth? __________ Have they been replaced? ___________________

Are you comfortable with the replacement? ___________________________________

Please describe: ____

How do you feel about the appearance of your smile? _________________________________

Are you interested in whitening your smile? ____________________________________

Please add anything that you feel is important: ______________________________________

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