

Dental History

Date of last dental visit: _____

Last cleaning: _____

Reason for today's visit: _____

How often do you:

Brush: _____

Floss: _____

Do you have or have you ever had:

- Orthodontic treatment?
- Missing teeth that you want replaced?
- Food catching between your teeth? Where? _____
- Bad breath?
- Gums that bleed when you brush or floss?
- Been told you have gum problems?
- Clench or grind your teeth during the day or at night?
- Wake up with sore jaw muscles?
- Have frequent headaches?
- Ever have pain in your jaw joint (around your ear)?
- Clicking or popping of jaw joint?
- An inability to open your mouth?
- A concern or fear of dental treatment?

Sensitivity to:

- Chewing Where? _____
- Hot or cold Where? _____
- Sweets Where? _____

Smile Evaluation:

Are you happy with the appearance of your teeth? _____

If you could make changes in your teeth what would they be?

- Color? _____
- Shape? _____
- Position? _____

Do you dislike the color of your old fillings? _____

Would you like to know more about how to enhance your smile? _____

What can we do to give you the best possible dental experience? _____