# DENTAL HISTORY

Patient Name _____ Date of birth _____

Do you have any specific dental problems? _____ □ Yes □ No

Do you have any active tooth decay? _____ □Yes □No

Do you have any broken teeth or restorations? _____ □Yes □ No

Do you have bleeding gums or history of periodontal disease? _____ □Yes □ No

Do you have any TMJ, jaw popping or clicking issues? _____ □ Yes □ No

Do you like the color and appearance of your teeth?_____ □ Yes □ No

Have you had your wisdom teeth removed? _____ □ Yes □ No

Do you grind or clench your teeth? _____ □ Yes □ No

Have you ever had problems with dental local anesthesia? _____ □ Yes □ No

Do you own/wear a dental retainer, bite guard or removable _____ □ Yes □ No
(partial or full) dentures?

Have you had orthodontic treatment? _____ □ Yes □ No

Are you interested in replacing any missing teeth? _____ □ Yes □ No

Do you use any specific dental tooth paste or mouth rinse? _____ □ Yes □ No

Do you floss and brush your teeth everyday? _____ □ Yes □ No

Do you smoke or chew tobacco? _____ □ Yes □ No

Date of last full mouth x-rays or panoramic x-ray? _____ □ Yes □ No

Do you have anxiety before dental visits? _____ □ Yes □ No

Doctor's comments:_____

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