DENTAL HISTORY

Date of last dental visit: _____

Previous dentist or practice name:_____

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

Are you happy with your smile? _____

Reason for your visit today: _____

Please check all that apply:

- ☐ Loose teeth
- ☐ Grinding teeth
- ☐ Frequent headaches
- ☐ Fillings
- ☐ Bleeding gums
- ☐ Lip or cheek biting
- ☐ Bad Breath
- ☐ Orthodontic treatment
- ☐ Dental pain
- ☐ Jaw Difficulty (clicking/pain)
- ☐ Periodontal treatment
- ☐ Sleep Apnea
- ☐ Jaw, Head or Neck injuries

Sensitivity to:

- ☐ Cold
- ☐ Hot
- ☐ Sweets
- ☐ When biting
- ☐ None

Do you have or have had any of the following:

- ☐ Dentures
- ☐ Partials
- ☐ Braces
- ☐ Invisalign/clear aligner therapy
- ☐ Orthodontic retainer(s)

Do you have any dental implants? Yes / No

If so, where? ☐ top left ☐ top right ☐ bottom left ☐ bottom right