DENTAL HISTORY FORM

PATIENT NAME _____ BIRTH DAY _____/_____/_____

Do your gums bleed when you brush or floss? ___YES ___NO If yes explain_____

Are your teeth sensitive to hot or cold? ___YES ___NO If yes explain_____

Have you had periodontal (gum) treatments? ___YES ___NO If yes explain_____

Have you had orthodontic treatment (braces)? ___YES ___NO If yes explain_____

Do you have a dry mouth? ___YES ___NO If yes explain_____

Do you have discomfort in your jaw joints? ___YES ___NO If yes explain_____

Do you clench or grind your teeth? ___YES ___NO If yes explain_____

Have you ever had to wear a night guard? ___YES ___NO If yes explain_____

Do you wear complete or partial dentures? ___YES ___NO If yes explain_____

Do you have anxiety over dental treatment? ___YES ___NO If yes explain_____

Are you unhappy with the color of your teeth? ___YES ___NO If yes explain_____

Have you ever had a serious injury to your mouth? ___YES ___NO If yes explain_____

Do you have crowding or spacing between your teeth that you are not happy with? ___YES ___NO If yes explain

_____

Do you have any issues that are not listed above? ___YES ___NO If yes explain_____

_____

What is your preferred Pharmacy? _____

OFFICE USE: _____

_____

_____

To the best of my knowledge, the questions on this form have been answered accurately. It is my responsibility to inform the dental office of any changes in my medical status.

Patient Signature _____ DATE _____/_____/_____

Guardian Signature (if under 18) _____ Relationship _____