Dental History

Previous Dentist:_____

Last x-rays: _____

Last Cleaning: _____

Major dental problem or reason for coming:_____

Do you have or had:

Yes No Bad breath
Yes No Bleeding Gums
Yes No Burning mouth
Yes No Clenching
Yes No Dry mouth
Yes No Grinding

Yes No Braces
Yes No Gum treatment or surgery
Yes No Injury to head or neck
Yes No Loose teeth
Yes No Jaw pain or tiredness
Yes No Mouthguard

Are you available to sit for a three hour dental appointment?_____

Are you active in sports?_____

Is there anything about the appearance of your smile you would like to change?_____

Did you ever avoid a dental appointment because you were frightened?_____

Have you ever been dissatisfied with dental treatment? Please describe_____

_____

Do not write below this line

ASA Class:_____ Dr. Signature_____ Date_____

Doctor's Notes:_____
_____
_____
_____
_____