Dental History

Do you have any dental or facial pain? _____ Yes _____ No

Are you interested in comprehensive care? _____ Yes _____ No

Are you apprehensive about dental care? _____ Yes _____ No

Are you looking to improve the appearance of your teeth? _____ Yes _____ No

Do you have sensitivity in your teeth to the following?

Hot _____ Yes _____ No

Cold _____ Yes _____ No

Sweets _____ Yes _____ No

Biting _____ Yes _____ No

If so, in what area? _____ UR _____ LR _____ UL _____ LL _____

Do you have problems in your jaw or joint (TMJ)? _____ Yes _____ No

Are you aware of jaw clenching or teeth grinding? _____ Yes _____ No

Do you believe it is important to save your teeth? _____ Yes _____ No

How often do you brush your teeth? _____ 2x daily _____ 1x daily _____ Sometimes

How often do you floss your teeth? _____ 2x daily _____ 1x daily _____ Sometimes

What is the approximate date of your last visit? _____ 6m – 1y _____ 2-4 Years _____ 5+ Years

Please help us get to know you better:

Are you married? _____ Yes _____ No

Do you have children? _____ Yes _____ No

Do you work outside of the home? _____ Yes _____ No

Are you tired of answering questions? _____ Yes _____ No

Do you have any hobbies? _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of my changes in medical status.

Signature: _____ Date: _____