Dental Health History

Name_____Birthdate_____Age_____

Former Dentist and Address _____

_____

Reason for Today's Visit: _____

Date of Last Dental Exam: _____

Were Dental Radiographs Taken at That Time? **O** Yes **O** No

If yes, what type of radiographs were taken? **O** Full Mouth Series **O** Bitewings **O** Other_____

How often do you Brush your Teeth? _____

What type of Brush do you use? **O** Manual **O** Electric what model? _____

How often do you Floss your Teeth? **O** Daily **O** Weekly **O** Monthly **O** Never

Do you use any of the following? **O** Antimicrobial Rinses O Fluoride Gels/Rinses

O Other Dental Devices, Specify _____

Do you have a desire to change your smile? **O** Yes **O** No

If yes, please specify _____

Have you had orthodontic work? **O** Yes **O** No

If yes, When? _____

Have you had periodontal treatment or dental surgery? **O** Yes **O** No

If yes, When? _____
Where? _____
What? _____

Have you had any unpleasant dental experiences or is there anything about dentistry that

you strongly dislike?_____

Please Check Any of the Following the Apply:

O Bad Breath
O Bleeding Gums
O Clicking or Popping Jaw
O Food Collection Between Teeth
O Grinding Teeth
O Loose Teeth or Broken Fillings
O Xerostomia (Dry Mouth)
O Sensitivity to Cold
O Sensitivity to Hot
O Sensitivity to Sweets
O Sensitivity to Biting
O Sores or Growths in Mouth