

Name: _____



Patient Dental History:

Previous Dentist: _____ Phone: _____

Last Dental Visit: _____ Last Date of X-Rays: _____

Have you ever had any of the following? Please circle answers below:

- | | | |
|--------------------------|-------------------------------|------------------------------------|
| Bad Breath | Cigar/ Cigarette Smoking | Clicking or Popping of Jaw |
| Bleeding Gums | Food Collection between teeth | Gums swollen or tender |
| Loose teeth | Broken fillings | Sensitivity to Hot or Cold |
| Sore or growths in mouth | Lip or cheek biting | Sensitivity when chewing or biting |

Have you ever injured or sustained any form of trauma to the following? (Please circle all that apply)

Head Neck Jaw

Have you ever had Periodontal Treatment?: Yes No Date of Treatment?: _____

Have you ever had Orthodontic Treatment?: Yes No Date Treatment Began: _____

Were third molar/wisdom teeth removed?: Yes No Date of Surgery: _____

Do you use bleaching/whitening products on your teeth?: Yes No What brand?: _____

Have you ever have TMJ problems?: Yes No

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE?

Daily Home Care Habits:

What type of toothbrush do you use? Manual Electric If Electric, what type: _____

How often do you floss? _____

Do you use a Waterpik? Y N

Please list any additional dental products used:

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian: _____ Date: _____