Dental History

Patient Name____ **Date of Birth** ________________________

Date and Place of Last Dental Visit _____________________________ Previous Dentist_______________________

Circle Appropriate Answer (*Leave blank if you do not understand any question*)

1. Are you currently in any dental pain or discomfort ? Yes/No
   If YES, explain ____________________________________
2. Do your gums bleed while brushing or flossing ? Yes / No
3. Are your teeth sensitive to hot or cold foods or drinks ? Yes / No
4. Are your teeth sensitive to sweet or sour foods or drinks ? Yes / No
5. Do you have any sores or lumps in or near your mouth ? Yes / No
6. Have you had any head, neck or jaw injuries ? Yes / No
7. Have you ever experienced any of the following problems in your jaw:
   - Clicking or popping Yes / No
   - Pain (joint, ear side of face) Yes / No
   - Difficulty in opening or closing Yes / No
   - Difficulty in chewing Yes / No
8. Do you have frequent headaches ? Yes / No
9. Do you clench or grind your teeth ? Yes / No
10. Do you bite your lips or cheeks frequently ? Yes / No
11. Did you have any difficult extractions in the past ? Yes / No
12. Did you have prolonged bleeding after extractions ? Yes / No
13. Have you had any orthodontic treatment(braces) ? Yes / No
14. Do you wear dentures or partials ? Yes / No
    If YES, date of placement ________________
15. Have you ever received instructions to care for your teeth ? Yes / No
16. Do you like your smile ? Yes / No

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful dental history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction.

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Signature of Patient (Parent or Guardian) **Date**

Dental History

Signature of Dentist	Date