DENTAL HISTORY

1. Purpose of initial visit: ______________________________
2. How long since your last dental visit? ______________________________
3. Previous dentist's name? ______________________________
4. Have you had dental x-rays taken within the past six months? ☐ yes ☐ no
5. Did you bring x-rays with you, or have they been sent to the office? ☐ yes ☐ no
6. Do you clench or grind your teeth? ☐ yes ☐ no
7. Are any of your teeth sensitive to: ☐ hot ☐ cold ☐ sweets ☐ pressure
8. Do your gums bleed or hurt? ☐ yes ☐ no
9. How often do you brush your teeth per day? ____ times
10. Do you use dental floss every day? ☐ yes ☐ no
11. Are you happy with the appearance of your teeth? ☐ yes ☐ no

If you are interested in discussing any of the listed procedures below, please make note of it.

☐ Crowns ☐ Porcelain Veneers ☐ Implants ☐ Partial Dentures

☐ TMJ Therapy ☐ Lightening Of Your Teeth ☐ Full Dentures

Comments regarding your dental concerns would be welcomed.

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Patient's Signature: ______________________________

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