It is important that we know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

DENTAL HISTORY

What is the reason for your visit today?_____

_____

How LONG SINCE you have seen a Dentist?_____ Date _____

What was done at that time? _____

_____

Cleaning ❑ Yes ❑ No X-Rays ❑ Yes ❑ No

	YES	NO
Are you having PAIN or DISCOMFORT now?	❑	❑
Have you lost any teeth?	❑	❑
Would you like to know more about PERMANENT REPLACEMENTS?	❑	❑
Have you had any PERIODONTAL (GUM) treatments?	❑	❑
Do your gums BLEED, or feel TENDER or IRRITATED?	❑	❑
Do you REGULARLY use DENTAL FLOSS?	❑	❑
Does food tend to get caught in between your teeth?	❑	❑
Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle)	❑	❑
Do you have LOOSE, TIPPED, or SHIFTING teeth? (circle)	❑	❑
Do you have problems with teeth/fillings BREAKING?	❑	❑
Are you UNHAPPY with the APPEARANCE of your teeth?	❑	❑
Are you aware of GRINDING or CLENCHING of your teeth?	❑	❑
Do you have any habits - smoking, gum chewing, hard candy, pens fingernails? (circle)	❑	❑
Do you have HEADACHES, EARACHES, or NECK PAINS?	❑	❑
Does your jaw pop or click, any soreness in the muscles of your face or around your ear?	❑	❑
Have you worn BRACES on your teeth? (ORTHODONTICS)	❑	❑
Do you have DISCOLORED teeth that bother you?	❑	❑
Would you like your smile to LOOK BETTER or DIFFERENT?	❑	❑
Have you had unpleasant dental experiences in the past?	❑	❑

Is there anything in dentistry you strongly dislike? _____

_____

Do you have any other questions or concerns? _____

_____

_____

_____