Dental History

Patient Name: _____

Name of Previous Dentist:_____ Date of Last Exam:_____

What is your main dental concern you want addressed?_____
_____

How would you rate your smile? 1(poor) – 10(perfect)_____

What would change about it if you could?_____

Do you have any of the following habits? (Circle)
Soft drinks- Regular or Diet, Tobacco use, Energy drinks, Chewing habits-hard candy or nails or gum, Clench or grind your teeth, Other oral habit?_____

Are there any discomfort/sensitivities in your mouth at this time? Y N
If yes, please explain_____

Do your gums bleed when brushing or flossing? Y N

Does your mouth feel dry often? Y N

Do you experience any jaw, joint, face muscle discomfort, or frequent headaches? Y N

Do you(or your significant other) have concerns with your snoring? Y N

Have you noticed your teeth getting shorter(wear)? Y N

If you are missing any teeth, do you want to know your options to replace them? Y N

Do you wear partial(s), denture(s), or occlusal splint(s) or have you in the past? Y N

Have you had your wisdom teeth removed? Y N

What is your water source? (Circle) Rural water, Well, City, Reverse Osmosis, Bottled

How often do you brush? _____ How often do you floss?_____

Who can we thank for referring you to our office?_____

Cell phone # _____ Email address _____

Which is the best way for you to receive your appointment reminders? (circle)

Text Email Phone