Dental History

Patient Name ____

Primary reason for this appointment ☐ Examination ☐ Emergency ☐ Consultation

1) Do you have a specific dental problem?

   Describe __________________________________

2) Do you think you have active decay? ___________________

3) Do you think you have gum disease? ___________________

4) Do your gums ever bleed? __________________________

5) Does food catch between your teeth? ___________________

6) Any loose teeth? ________________________________

7) Do you ever have popping, clicking, or discomfort in your jaw joint? _________

8) Do you brux or grind? _____________________________

9) Do you smoke or chew? If yes, how much per day? _____________

10) Do you daily drink liquids that have sugar in them (e.g., sodas, coffee, tea, etc.)?____

11) Name of previous dentist? ____________________________

12) Do you have dental examintations on a regular basis? Last visit? ___________

13) Date of your last cleaning? ____________________________

14) How often do you brush? ___________Floss? ______________

15) Have your past experiences in a dental office always been positive? __________

16) Do you like your smile? _________ If not, why? __________________

17) Do you want to keep your remaining teeth? _______________________