

# Dental History

For New Patients

Name \_\_\_\_\_ Birth date \_\_\_\_\_

What is the reason for your visit today? \_\_\_\_\_

When was your last dental visit? \_\_\_\_\_ Were x-rays taken? \_\_\_\_\_

Who was your previous dentist? \_\_\_\_\_ Address \_\_\_\_\_

Anything you would like us to know about your previous dental experiences? \_\_\_\_\_

Please answer **Yes** or **No** as they apply to you:

**YES**   **NO**

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Are you in any dental pain? Where? _____                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you having any gum problems?                               |
| <input type="checkbox"/> | <input type="checkbox"/> | Are your teeth sensitive in any way? How? _____                |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you having any jaw discomfort or pain?                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Does your jaw click, pop or get stuck?                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you clench or grind your teeth?                             |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you worn braces to straighten your teeth?                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been treated by a periodontist (gum specialist)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you happy with the color of your teeth?                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you happy with the shape of your teeth?                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you brush daily? Manual or electric tooth brush? _____      |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you floss daily?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Do use any type of fluoride? What kind? _____                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you snore?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Has anyone ever observed you to stop breathing during sleep?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been diagnosed with sleep apnea?                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever used a CPAP machine?      Frequency? _____       |

Is there anything else we should know about you dental history? \_\_\_\_\_