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? __________

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

YES	NO	
☐	☐	Are you in any dental pain? Where? ____________________________
☐	☐	Are you having any gum problems?
☐	☐	Are your teeth sensitive in any way? How? _________________________
☐	☐	Are you having any jaw discomfort or pain?
☐	☐	Does your jaw click, pop or get stuck?
☐	☐	Do you clench or grind your teeth?
☐	☐	Have you worn braces to straighten your teeth?
☐	☐	Have you ever been treated by a periodontist (gum specialist)?
☐	☐	Are you happy with the color of your teeth?
☐	☐	Are you happy with the shape of your teeth?
☐	☐	Do you brush daily? Manual or electric tooth brush? _______________
☐	☐	Do you floss daily?
☐	☐	Do use any type of fluoride? What kind? _________________________
☐	☐	Do you snore?
☐	☐	Has anyone ever observed you to stop breathing during sleep?
☐	☐	Have you ever been diagnosed with sleep apnea?
☐	☐	Have you ever used a CPAP machine? Frequency?______________

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

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