

Dental History



Former Dentist _____

Date of last Exam, Cleaning _____ Date of last Full Mouth X-rays (16-18) _____

Reason for today's visit _____

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

Type of bristles on your toothbrush ___ Hard ___ Medium ___ Soft

Do your gums ever bleed? ___ Yes ___ No

Have you ever had periodontal disease? _____

Please check if you have had any of the following:

- | | | |
|------------------------------------------|------------------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Sensitivity to hot | <input type="checkbox"/> Clicking or popping of jaw |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Food collecting between teeth |
| <input type="checkbox"/> Broken fillings | <input type="checkbox"/> Sensitivity to sweets | <input type="checkbox"/> Sensitivity when biting down |
| <input type="checkbox"/> Loose teeth | <input type="checkbox"/> Grinding of teeth | |

Are you unhappy with the appearance of your teeth? ___ If yes, what would you like to change? _____

Do you have discolored teeth that bother you? _____

Is there anything you would like to change about your smile? _____

If yes, what would you like to change? _____

Do you want to learn more about whitening of teeth? _____