# dental history

Name _____ Birthday _____

## dental care

Name of previous dental office _____

Telephone number _____ Date of last cleaning _____

Date of last dental visit _____

What was your last dental visit for? _____

## dental hygiene

**How often do you brush your teeth?**

○ 2x Daily ○ Daily ○ A few times a week ○ Sometimes ○ Rarely ○ Never

**How often do you floss?**

○ Daily ○ A few times a week ○ Sometimes ○ Rarely ○ Never

**Do you get fluoride in your diet?** ○ Yes ○ No ○ I'm not sure

***Please list any dental products you use other than a toothbrush, toothpaste, and floss***

***Please list any dental issues that you are experiencing right now***



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## dental issues

***Circle any of the following that apply to you:***

**I am sensitive to...**

☐ Hot or cold ☐ Sweets ☐ Biting down ☐ Chewing ☐ Brushing/Flossing

**I feel like I...**

☐ Clench my teeth ☐ Mouth breathe at night ☐ Have a sore jaw in the morning

☐ Use tobacco products ☐ Snore ☐ Bite my lips and/or cheeks accidentally

☐ Grind my teeth ☐ Chew foreign objects with my teeth (pencils, pipes, pins, nails)

**I have had...**

☐ Orthodontic treatment ☐ A mouth guard ☐ Periodontal treatment

☐ Oral surgery ☐ Trauma to the head or mouth

***Please describe*** _____

**I have experienced...**

☐ Clicking or popping of my jaw ☐ Joint/Ear/facial pain related to my jaw

☐ Difficulty in opening or closing my jaw ☐ Difficulty in chewing on either side

☐ Headaches or migraines that are worse in the morning

***Please describe*** _____



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## today's visit

What brought you in today?

Are there any parts of visiting the dentist that are particularly anxiety-inducing for you?

Have you ever had a bad dental experience before, and is there anything we can do to make today's experience more comfortable?

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