

Dental History Form

Why have you come to the dental office today?

Are you having dental pain or discomfort at this time? Yes No

Your overall dental health is: Good Fair Poor

Have you ever had a serious / difficult problem associated with any previous dental work? Yes No

Approximately when was your most recent dental visit? _____

Have you ever been told by a previous dentist or physician that you require an antibiotic premedication prior to dental visits? Yes No

Do you have or have you had:

Frequent toothaches: Yes No

Pain to biting or chewing: Yes No

Sensitivity in any of your teeth to hot or cold: Yes No

Periodontal (gum) disease: Yes No

Gums that bleed with brushing or flossing: Yes No

Orthodontic treatment (braces): Yes No

Difficulty in opening or closing your jaw / pain or discomfort in your jaw joint (TMJ/ TMD): Yes No

Do you grind or clench your teeth? Yes No

Do you like your smile? Yes No

Are you satisfied with the shape and / or shade of your teeth? Yes No

Do you brush Daily? Yes No How many times a day do you brush? _____

Do you floss Daily? Yes No How many times a week do you floss? _____

Have you ever smoked? Yes No

Do you currently smoke? Yes No How Much? _____

To the best of my knowledge, the preceding answers are correct and true. I hereby give my consent for the dental staff to perform necessary dental services, with my informed consent, needed during diagnosis and treatment. If at anytime I have any questions about the treatment I am receiving, they will be promptly answered.

Signature

Date