

## DENTAL HISTORY

	Yes	No
Do you have a dental problem now?.....	___	___
If yes, please explain _____		
Do you have or have you been treated for TMJ problems?.....	___	___
Do you clench or grind your teeth?.....	___	___
Do you wear a splint or mouthguard?.....	___	___
Are any of your teeth sensitive to hot, cold or sweets?.....	___	___
Have you had gum treatment or surgery?.....	___	___
Have you ever had a root canal?.....	___	___
Have you ever had orthodontic treatment?.....	___	___
Do you ever feel self-conscious about your breath?.....	___	___
Do your gums ever bleed?.....	___	___
Are you happy with the appearance of your teeth?.....	___	___
Would you like your teeth to be whiter?.....	___	___
Is there anything about your smile that you wish you could change?	___	___

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How often do you brush your teeth each day?

\_\_\_ 1-2 times      \_\_\_ 2-3 times      \_\_\_ 3 + times

How often do you floss?

\_\_\_ Daily      \_\_\_ Weekly      \_\_\_ Infrequently

Have you ever had instruction on the correct method of brushing?

\_\_\_      \_\_\_

When was your last dental visit and for what reason did you seek dental care? \_\_\_\_\_

Do you have any specific questions you would like to discuss?

\_\_\_      \_\_\_

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Patient/Parent Signature

\_\_\_\_\_  
Date