

Date: _____

Dental Information

Last Name: _____ First Name: _____ M.I. _____

Your Dental History

What is the reason for your visit today? _____

What is the date of your last dental visit? _____

Does dental work make you anxious? _____ Yes No

Have you had any bad experiences at the dentist? _____ Yes No

Have you ever had problems with dental anesthetics? _____ Yes No

Do you have any allergies related to dental work? _____ Yes No

Do your gums bleed while brushing, flossing, or on their own? _____ Yes No

Have you ever been diagnosed with gum disease? _____ Yes No

Are any of your teeth loose? _____ Yes No

Are any of your teeth sensitive to hot and/or cold? _____ Yes No

Have you ever had braces? _____ Yes No

Have you had your wisdom teeth removed? _____ Yes No

Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ Yes No

Do you feel like your lower jaw is being pushed back when you bite your teeth together? _____ Yes No

Do you avoid or have difficulty chewing gum, carrots , nuts, bagels, or other hard, dry food? _____ Yes No

Have your teeth changed in the last 5 years, have they become shorter, thinner or worn? _____ Yes No

Are your teeth becoming more crooked, crowded, or overlapped? _____ Yes No

Do you have more than one bite, squeeze, or do you shift your jaw to make your teeth fit together? _____ Yes No

Do you place your tongue between your teeth or rest your teeth against your tongue? _____ Yes No

Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ Yes No

Do you clench your teeth in the daytime, or do they feel sore? _____ Yes No

Do you have any problems with sleep, wake up with a headache, or an awareness of your teeth? _____ Yes No

Do you wear or have you ever worn a bite appliance? _____ Yes No

Are you happy with your smile? _____ Yes No

Are you happy with the color of your teeth? _____ Yes No

Are you interested in what cosmetic dentistry can do for your smile? _____ Yes No

Please list what you would like to change about your smile: _____

Please tell us any other concerns you have about your dental treatment: _____