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DENTAL HISTORY

Patient Name:_____ Date: _____

1. What is your primary concern? _____
_____.

2. Is there anything you dislike about the appearance of your teeth? _____
_____

3. When was your last dental exam?_____ Cleaning? _____

4. Have you had any of the following? Root Canal Y N Gum Surgery Y N Braces Y N
Retainers Y N Extractions Y N

5. Do you have any removable appliances? Y N If yes, how long? _____

6. Do you snack between meals? Y N If yes, describe _____
_____

7. Do you drink sodas, koolaid, coffee/tea? Y N How much? _____

8. How do you take care of your teeth on a daily basis? Brush _____ times a day Floss _____ time(s) a day
Toothbrush: Hard Medium Soft
Mouthrinse Y N Brand_____
Other _____

9. Have you been shown the proper way to brush & floss by a dental professional? Y N

10. Do you notice your gums bleeding or feeling tender when you brush or floss? Y N
Where?_____ How Long? _____

11. Do you have a problem with bad breath? Y N
Notes: _____

12. Are you aware of any loose teeth? Y N Where? _____

How Long? _____