Dental History Form

Patient First Name *

Patient Last Name *

Birth Date *
__/__/____

Reason for your visit today

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

Does the crowding of the teeth bother you? *
Yes No

Are you interested in a straighter, whiter smile? *
Yes No

Date of last cleaning and exam

Do you have any of the following?

- Eating disorder
- Sleep apnea
- Substance abuse
- Mouth breathing
- Snoring
- Teeth grinding / clenching

Are you happy with your smile? *
Yes No

Are your teeth sensitive to heat, cold, or anything else? *
Yes No

Have you ever had an adverse reaction to dental anesthetic? *
Yes No

Are you nervous about having dental treatment? *
Yes No

Do your gums bleed when you brush or floss? *
Yes No

Have you had braces? *
Yes No

Have you had treatment for jaw joint problem? *
Yes No