

Name _____

Date _____

DENTAL HISTORY

1. Reason for today's visit _____

2. Are you currently in pain _____

3. Do your gums ever bleed? Yes No

4. Have you ever had periodontal (gum) disease? Yes No

5. Do you have a family history of periodontal disease? Yes No

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

7. Are you aware of clenching or grinding your teeth? Yes No

8. Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? Yes No

9. Would you like whiter teeth? Yes No

10. Are you happy with the way your smile looks? Yes No

If not, what would you change? _____

10. Have you had previous orthodontic treatment? Yes No

11. Would you be interested in orthodontics (bracketing or Invisalign) to straighten your teeth? Yes No

12. Former Dentist _____

City/State _____

Date of last visit _____

Date of last dental x-rays _____

13. Referred by _____