Patient Name: ____ Today's Date: _____/_____/_________

When was your last dental visit? _____/_____/__________

Do you have or have you ever noticed any of the following?

- ☐ Bite your lips or cheeks
- ☐ Clench or grind your teeth
- ☐ Have noises or pain in your jaw joint
- ☐ Have pain in your teeth
- ☐ Food gets caught between your teeth
- ☐ Frequent headaches
- ☐ Gums bleed when you brush or floss
- ☐ Had a head injury(s)
- ☐ Had jaw injury(s)
- ☐ Had neck injury(s)
- ☐ Had your jaw lock open or shut
- ☐ Noticed your teeth becoming loose
- ☐ Your teeth shifting
- ☐ Sores, lumps, or tumors in your head or neck
- ☐ Teeth ache or are sensitive to hot or cold
- ☐ Teeth ache or are sensitive when eating

Give history of any box checked above.

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Dental Care Information

Yes	No	
☐	☐	Do you brush your teeth daily?
☐	☐	Do you floss your teeth daily?
☐	☐	Do you use a soft bristled tooth brush?
☐	☐	Have you ever had braces?
☐	☐	Have you ever had gum treatment?
☐	☐	Have you ever had any problems or troubles during dental treatment?
☐	☐	Are you happy with your smile?
☐	☐	Is there anything you would like to change about your smile?

Give history of any box checked above.

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By signing, you are verifying the above information to be true to the best of your knowledge.

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Signature of Patient, Parent of Patient, or of Legal Guardianof Patient

DENTAL HISTORY