Dental History

Name: _____

Date of last COMPLETE DENTAL exam:_____

Name of previous Dentist:_____

Date of last FULL MOUTH XRAYS:_____

Are you having problems now? (If so, explain)_____

Do you wear DENTURES or removable PARTIALS? Yes No

If so, are you happy with them? Yes No

Do your gums BLEED, or feel TENDER or IRRITATED? Yes No

Are your teeth sensitive to HOT, COLD, SWEETS OR PRESSURE? (circle) No

Are you UNhappy with the appearance of your teeth? Yes No

Are you aware of GRINDING or CLENCHING your teeth? Yes No

Do you have HEADACHES, EARACHES or NECK PAIN? No

Have you had PERIODONTAL (GUM) treatments? Yes (Dr._____) No

Have you worn BRACES (ORTHODONTICS)? Yes (Dr: _____) No

Have you had your WISDOM TEETH taken out? Yes (Year:_____) No

Are you interested in BLEACHING your teeth? Yes No