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## Dental History Form

**Patient Name:** _____ (Last) _____ (First) ____ (MI) _____ (Preferred Name)

**How would you rate the condition of your mouth?**

◯ Excellent ◯ Good ◯ Fair ◯ Poor

**Name & Phone Number of your previous dentist:**

_____

_____

**I routinely see a dentist every: ***

◯ 3 mos ◯ 4 mos ◯ 6 mos ◯ 12 mos ◯ Not routinely

**Approximate date of most recent dental exam and/or dental x-rays:**

_____

_____

**How can we help you today? ***

_____

_____

**I have experienced: (Check all that apply)**

- ☐ Complications from past dental treatment
- ☐ Past/Present braces or orthodontic treatment
- ☐ Sensitive to hot, cold, biting, sweets
- ☐ Whitened or bleached your teeth
- ☐ Difficulty chewing
- ☐ Currently or previously wore a bite appliance
- ☐ Gums bleed when brushing or flossing
- ☐ Bone loss around your teeth
- ☐ Experienced gum recession
- ☐ Extractions
- ☐ Trouble getting numb and/or Reactions to local anesthetic
- ☐ Dry mouth
- ☐ Food gets trapped between teeth
- ☐ Popping and/or clicking of your jaw joint
- ☐ Clenching or grinding of teeth
- ☐ Wears removable partial/denture
- ☐ Diagnosed and/or treated for gum disease
- ☐ Noticed an unpleasant taste or odor in your mouth
- ☐ Teeth become loose on their own (without injury)

**If any of the checked boxes need further explanation, please describe:**

_____

_____

_____

☐ ***By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. This will serve as my electronic signature.**

**Name of Patient/Parent or Guardian completing this form: ***

_____

_____

**Response Date:** ____/____/_____