Dental History

Patient Name_____**Date**_____

How did you hear of our practice?

( )AD ( )Internet ( ) Insurance Company ( )The Bear ( )Family/Friend whom?_____

Reason you made this appointment?_____

When did you last visit the dentist_____ and where did you go_____

How often did you go to the dentist?_____

Have you ever had an unpleasant experience at the dentist?_____EXPLAIN_____

Does dental treatment make you nervous? ( ) No ( )Yes -if yes ( ) Moderately ( )Extremely

How often do you brush your teeth?_____ Floss?_____

Do you use a fluoride or other rinse? If yes how often?_____

Do you use any other dental aids? (toothpicks, electric toothbrush, etc)_____

Does food tend to get caught between teeth?____Do your gums bleed when you brush?_____

Please check all that apply

( )unpleasant taste/bad breath	( )Swelling/lumps in mouth	( )teeth sensitive to hot
( )Clicking/popping jaw	( )Loose teeth	( )teeth sensitive to cold
( )Difficulty opening/closing jaw	( )burning tongue/lips	( )teeth sensitive to sweets
( )Clenching/Grinding teeth	( ) mouth breathing	( ) snoring

Have you ever had:	**Yes**	**No**
Oral Surgery (wisdom teeth extracted etc)	( )	( )
Orthodontic treatment (braces)	( )	( )
Periodontal treatment (gum treatment)	( )	( )
Cosmetic dentistry	( )	( )

What ideally would you change about your teeth or smile?_____