DENTAL HISTORY - CONFIDENTIAL

Patient Full Name*

Patient Birth Date*

What is your main reason for being here today?

When was your last dental visit?

Do you have painful or sensitive teeth?

☐ Yes ☐ No

If so, where?

Do your gums bleed easily, especially when you brush or floss?

☐ Yes ☐ No

Have you noticed any slow healing sores in or about your mouth?

☐ Yes ☐ No

Do you have difficulty chewing your food?

☐ Yes ☐ No

Do you have any discomfort or noise in your jaw joint?

☐ Yes ☐ No

Do you have difficulty opening as wide as you would like?

☐ Yes ☐ No

Are you dissatisfied with the appearance of your teeth?

☐ Yes ☐ No

How often do you brush?

How often do you floss?

Do you have any problems, concerns or comments about previous dental treatment?

Who may we thank for referring you to our office?

SIGNATURE

DATE$$$*mm-dd-yyyy*