♣ Dental History

Name: **Date:**

1. What services are you seeking?		
2. How would you describe your past dental experiences?	Good Fair Poor	
3. List your main concerns in the order of 1 to 4.	Economy_____ Time_____ Quality_____ Comfort_____	
4. When and what services were performed in the last dental appointment?	When_____ Services_____	
5. How long has it been since you had a thorough evaluation of your mouth?	a. Teeth Cleaned? _____ b. X-rays of your entire mouth? _____	
6. A. I brush my teeth B. floss them	_____ /day _____/week	
7. Do your gums bleed?	Y	N
8. Have you been treated for gum disease?	Y	N
9. Are you a smoker?	Y	N
	How much? /day	
10. Have you had dental implant in the past?	Y	N
11. Have you been treated for cosmetic?	Porcelain Veneer	All. Por crown
12. Have you ever worn braces?	Y	N
	WHEN?	
13. Are you teeth sensitive to	HOT COLD SWEET	
14. Do you clench or grind your teeth?	Y	N
15. Have you ever had or been treated for TMJ or jaw joint problems?	Y	N
16. Is there something else that we should know about your mouth?		

Signature_____ **Assistant**_____