

Dental History

Are you happy with the appearance of your teeth? Y N

Is there anything you would like to change about your smile? Y N

Have you ever had any complications following dental treatment Y N

Please explain _____

When was your last dental visit? _____

Do you have any pain in your teeth? Y N

Do you have any clicking or pain in your jaw? Y N

Do you have problems opening for extended periods of time? Y N

Do your gums bleed while brushing? Y N

How often do you brush? _____

What type of toothpaste do you use? _____

Do you use mouthwash? Y N

How often do you floss? _____

Do you smoke? Y N

How much? _____

Do you use chewing tobacco? Y N

Do you drink alcoholic beverages? Y N

How much? _____

Have you ever had orthodontic treatment (braces) Y N

Have you ever had any periodontal treatment (deep cleaning, gum surgery) Y N

Do you have a bite plate or night guard Y N

Have you ever had any serious injury to your mouth or head? Y N

Is there any other information that you feel is relevant to your dental treatment?
