

DENTAL HISTORY

What is your main concern about your dental condition? _____

Name of your dentist: _____

City/Town _____ Phone Number _____

Yes No ?? Have you ever had dental x-rays? Date of last x-rays: _____

Yes No ?? Have you experienced any complications following dental treatment? If yes, please explain:

Yes No ?? Are your teeth sensitive to temperature, pressure, or certain foods?

Yes No ?? Have you ever received instruction on proper tooth brushing technique?

Yes No ?? Do your gums bleed when brushed?

Yes No ?? Have you had any clicking or pain in your jaw joints? If yes, please explain:

Yes No ?? Have you inherited any family facial or dental characteristics? If yes, please explain:

Yes No ?? Are you a mouth breather? While Awake? While asleep?

Yes No ?? Have you ever injured your teeth? _____

Yes No ?? Have you ever injured your jaw or face? _____

Yes No ?? Have you been informed of any missing or extra permanent teeth?

Yes No ?? Did you suck your finger or thumb? Until what age? _____

Yes No ?? Has an orthodontist been consulted previously?

Yes No ?? Any musical instruments played? List: _____

Do you have any other dental problems we should know about? Yes No Please explain: _____

If you submitted this form through the web, would you like us to call you? Yes No

Whom may we thank for referring you to our office? _____

How else did you hear about us? Check all that apply.

Phone Book

Sign/Banner

Website

Mailer/Magnet

Doctor's Office

Other _____

Signature _____

Please do not forget to fill out a HIPAA privacy form. If you did not receive one, ask for one now.