Dental History

Who may we thank for inviting you to our office?______________________________

When was your last visit to a dentist?____

When were your last Full Mouth X-rays taken?________________________________

Why did you leave your last dentist?____

Do you wear a removable appliance (partials, dentures)? Yes/ No

If so are you happy with them? Yes/ No

If **NO**, why not?____

Are your teeth or gums sensitive when you brush? Yes/ No

Do your gums bleed when you brush? Yes/ No

Do you have frequent headaches, earaches, or jawaches? Yes/ No

Do you grind or clench your teeth at night or during the day? Yes/ No

Is there anything specific you want to change or make better about your teeth or gums? ____

Have you had a bad experience in the past at a dental office? Yes/ No

Are you nervous in the dental chair? Yes/ No

Would you be interested in using nitrous oxide (laughing gas), headphones, or watch a DVD to help you relax during treatment?_____________________________

Do you have goals for your dental treatment?_________________________________

Do you like your smile? Yes/ No

If not how would you change your smile?_______________________________