Dental History

PATIENTS NAME _____ Today's Date _____

Please answer the following questions:

Please list your dental complaints or concerns, if any. _____

_____

Are you having any pain or discomfort at this time? ---------- Yes No

Do you have sensitive teeth? IF so, when? _____ Yes No

When was your last visit to a dentist?

_____

What services were provided? _____

Who was you former dentist? _____

General Risk – Self Assessment

Does your mouth seem dry? ---------- Yes No

During the day, do you eat and snack on sugary foods, drinks, gum, or mints? ---------- Yes No

Are you nervous about having dental treatment? ---------- Yes No

Have any of your family members had gum disease? ---------- Yes No

Have any of your family members had excessive cavities? ---------- Yes No

Have you had, or have you ever been told that you have "gum disease", "deep pockets",

or periodontal disease? ---------- Yes No

Currently do you have sore or bleeding gums? ---------- Yes No

Do you seem to have new cavities at each dental check up? ---------- Yes No

Do you grind or clinch your teeth? ---------- Yes No

How do you feel about the color of your teeth? _____

What do you want to accomplish in terms of your oral health?_____

_____