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## *DENTAL HEALTH HISTORY*

Please provide the practice with your medication list, strengths, dosage and reason administered and if you will be removing/changing any medication soon.

**Patient Name** _____ **Date** _____

The information you will provide will assist the doctor and our office team to understand your dental health and needs. If there have been any changes to your health, please inform the staff upon each visit.
If you have a night guard, sports guard, snore guard, retainer, partial or denture and did not bring it with you please inform the clinical staff. The doctor suggests that you please bring them with you to every dental visit to evaluate and observe the function and condition.

Please explain your reason for your dental visit today, please check yes or no to the questions below. Please do not leave any questions unanswered on this form or your health history. If you have any questions please feel free to ask the staff to assist you in answering the questions correctly.

Yes/No

___/___ Do you like your smile? What changes would you make if you could?
_____

___/___ Are you having discomfort associated with your gums/teeth/throat? If so where,
_____

___/___ Do you have any sensitivity to hot, cold sweets or chewing, please indicate upper/lower left or right front or back and which of these are you sensitive too?
_____

___/___ Does a dental treatment make you nervous?
___/___ Are your teeth turning yellow or losing brightness?
___/___ Do you drink coffee or tea?
___/___ Do you play contact sports?
___/___ Have you had orthodontics? If so when and what kind? _____
___/___ Has fear ever prevented you from seeking dental treatment?
___/___ Have you ever had a bad dental experience?
___/___ Are your jaws/teeth sore in the morning ?
___/___ Have you ever had trauma to the face/teeth with a fall, auto accident, sports or altercation?
___/___ Have you ever had food caught between your teeth? Where _____
___/___ Do you want to save your teeth?

**Have you ever experienced any of the following? Yes/No**

___/___Snoring or Sleep Apnea ___/___Bad Breath ___/___Bleeding gums
___/___Grinding/clenching ___/___Headaches ___/___Clicking/popping of jaw

**If you could make any changes to your smile you would want them: Yes/No**

___/___Whiter Replace stained front fillings ___/___Remove Silver Fillings
___/___Straighten and/or close spaces ___/___Repair broken and/or chipped teeth

**Are you interested in Clear braces, Fast Braces, Veneers or implants? Yes/No**

_____

**Hygiene**

How often do you brush? _____ Do you use a manual, electric, hard or soft toothbrush
Do you have dry mouth Yes/No Do you floss Yes/No Mouthwash Yes/No
When was your last dental cleaning? _____ Do your gums bleed when you brush/floss? Yes/No
Have you had periodontal problems and/or a deep Cleaning Yes/No