DENTAL HISTORY QUESTIONAIRE

Today's Date: _____ Name:_____ Date of Birth:_____

What is the reason for your visit today?

___ Examination /Cleaning ___ Toothache ___ Other _____

When was the last time you were seen by a dentist for a cleaning? _____

When was the last time you were seen by a dentist for a complete dental exam? _____

When was the last time you had x-rays taken? _____How often do you have dental examinations?

_____Twice per year _____Once per year _____Every few years

Are you using any dental devices (i.e. retainer, bite guard, etc.)? _____ Yes _____ No

★ If yes, please describe: _____

Do you have any dental problems now or feel pain to any of your teeth? _____ Yes _____ No

★ If yes, please describe: _____

Are your teeth sensitive to any of the following: ___ Hot/Cold ___ Sweets ___ Biting/Chewing

Do you clench or grind your teeth? _____ Yes _____ No

Do you have tired jaws, especially in the mornings? _____Yes _____ No ___

Do you like your smile? _____ Yes _____ No

Have you ever had orthodontic treatment (i.e. braces, retainer, etc.)? _____ Yes _____ No

Are you interested in doing cosmetic treatment (i.e. teeth whitening, veneers, straightening teeth, changing your smile)? _____ Yes _____ No

Is there anything else about having dental treatment that you would like us to know? (If yes, please describe.) _____ Yes _____ No

Comments: _____

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