It is important to tell all dental personnel involved in your treatment about the general state of your health. This information is confidential.

Name _____ Date of Birth _____

1. Former Dentist _____ Address _____
2. When did you last visit a dentist? _____ X-rays taken? Yes ____ No ____
   What was done at that time? _____
   Why did you leave that practice? _____
3. Have you lost or have had any teeth removed, including wisdom teeth? Yes ____ No ____
   Why? _____
4. Do you have any bridge work or dentures? _____
5. Are you unhappy with the replacement? Yes ____ No ____ Why _____
6. Do you feel your breath is offensive at times? Yes ____ No ____
7. Have you ever been told you have gum disease? Yes ____ No ____
8. Have you ever had gum treatment or Surgery? Yes ____ No ____
9. Does food chronically collect between your teeth? Yes ____ No ____
10. Are your teeth acutely sensitive to: Sweet ❑ Cold ❑ Heat ❑ Pressure ❑ No ❑
11. How often do you brush your teeth? _____
12. How often do you floss your teeth? _____
13. Do you clench or grind your teeth? Yes ____ No ____
14. Does your jaw click or pop? Yes ____ No ____
15. Do you have frequent headaches? Yes ____ No ____
16. Have you had any orthodontic work? Yes ____ No ____
17. Has any dental treatment been recommended to you that you have not had done? _____
18. Are you happy with the appearance of your smile? Yes ____ No ____ Explain _____
19. Anything else that would be valuable for me to know? Yes ____ No ____ Explain _____

I certify that the above information is complete and accurate.

Patient's/Guardian's Signature _____ Date _____

DENTAL HISTORY REPORT