Dental History

Patient Name: _____

Reason for Today's Visit_____ Date of last dental care_____

Former Dentist_____ Date of last dental X-rays_____

Address_____

Check (✓) if you have had problems with any of the following

☐ Bad breath	☐ Grinding teeth	☐ Sensitivity to hot
☐ Bleeding gums	☐ Loose teeth or broken fillings	☐ Sensitivity to sweets
☐ Clicking or popping jaw	☐ Periodontal treatment	☐ Sensitivity when biting
☐ Food collection between teeth	☐ Sensitivity to cold	☐ Sores or growths in your mouth

How often do you floss?_____ How often do you brush?_____

How did you hear about our office? _____

Referred by: _____