# Dental History

Patient Name: _____

**How do you feel about dental treatment?**

☐Relaxed ☐A Little Uneasy ☐Tense ☐Anxious ☐Very Anxious

**Have you seen a dentist before?**

☐Yes ☐No

**Have you avoided regular dental care?**

☐Yes ☐No

**If so, when was your last visit?** ☐3-6 months ago ☐7-11 months ago ☐1 yr ago ☐over 2yrs ago

**How often do you brush?**

☐Once per day ☐Twice per day ☐Three times per day

**How often do you floss?**

☐Less than once per day ☐Once per day ☐More than once per day

**Would you like your teeth to be straighter?**

☐Yes ☐No

**Would you like your teeth to be whiter?**

☐Yes ☐No

**How would you rate your previous dental experience?** ☐ Excellent ☐ Good ☐Average ☐ Poor

**Previous Dental Office Name*:** _____ **Phone Number*:**_____

**This information is used only to request previous x-rays if needed*

**Do you have, or have you had any of the following dental concerns? *Please check all that apply.***

| | | |
|---|---|---|
| ☐Aching/Sensitive Teeth | ☐Orthodontic Treatment | ☐Gum Infection/Disease |
| ☐Areas of Food Traps | ☐Swelling/lumps in mouth | ☐Loose Teeth |
| ☐Broken Filling(s) | ☐Grinding/Clenching | ☐ Jaw Pain |
| ☐Cavities | ☐Bad Breath | ☐Clicking/Popping Jaw |
| ☐Dry Mouth | ☐Broken/Missing Teeth | ☐Implants |
| ☐Bleeding Gums | ☐Gag Easily | ☐None of the Above |

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in status.

**Signature :** _____ **Date:** _____

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