DENTAL HISTORY

Reason for today's visit_____ Date of last dental visit_____

Former Dentist_____ Date of last dental X-rays_____

Address_____

Check(/) if you have had any of the following:

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

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

After reading this dental history, I have answered the questions to the best of my knowledge and correctly.

Signature: _____