Dental History Form

DENTAL HISTORY FORM

PATIENT NAME: **(PREFERRED):** **DATE:**

Please describe the primary reason for your visit (concerns):

1. _____
2. _____
3. _____

4. How long has this been going on and what would you like done?

_____

_____

5. If you could rate your smile from 1 - 10, what would it be? _____

6. Would you like to improve your smile? Y N How? _____

_____

Have you ever suffered from, or been told you may have any of the following?

7. Gum disease	**Y**	**N**	**11. Malocclusion**	**Y**	**N**
8. Bruxism or Grinding	**Y**	**N**	**12. Bad Breath**	**Y**	**N**
9. Jaw pain or TMJ	**Y**	**N**	**13. Headacheds or Migrains**	**Y**	**N**
10. Dental pain	**Y**	**N**	**14. Tooth Secitivity to Hot/Cold**	**Y**	**N**

DOCTOR'S NOTES: _____