DENTAL HISTORY

1. Date of last dental visit? ______ Dentist's name ______ Phone ______
2. Did you have x-rays taken? . . . . ❑ Yes ❑ No
3. Have you had all your teeth x-rayed in the past 3 years? . . . . ❑ Yes ❑ No
4. How do you feel about your past dental work? ______
5. Have you ever had any problem or complications associated with previous dental treatment? If yes, please explain . . . . ❑ Yes ❑ No ______
6. Do you wear full or partial dentures? . . . . ❑ Yes ❑ No (If Yes) How old are they? ______
7. What are your prime concerns? ______
8. Are you happy with your smile? (tooth color; tooth shape; spaces etc.) . . . . ❑ Yes ❑ No
9. Do your gums bleed when brushing? . . . . ❑ Yes ❑ No Flossing? . . . . ❑ Yes ❑ No
10. Do you have an unpleasant odor or taste in your mouth? . . . . ❑ Yes ❑ No
11. Have you had gum disease or pyorrhea? . . . . ❑ Yes ❑ No
12. Is your mouth or are your teeth sensitive to pressure? . . . . ❑ Yes ❑ No Hot/Cold? . . . . ❑ Yes ❑ No
13. Does food catch between your teeth? . . . . ❑ Yes ❑ No
14. Have you had orthodontic treatment? . . . . ❑ Yes ❑ No
15. Do you clench or grind your teeth during the day or night? . . . . ❑ Yes ❑ No
16. Have you ever had pain in your jaw joint or your face (in and about your ears)? . . . . . . ❑ Yes ❑ No
17. Does your jaw joint click? . . . . ❑ Yes ❑ No Do you have difficulty opening your mouth widely? . . . . ❑ Yes ❑ No
18. Please add anything you feel is important for the doctor to know ______

We may request/report credit information to TRW, a credit rating institution

Patient's Signature ______ Date ______