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DENTAL HISTORY
| DOB:

General Information

Who was your previous Dentist and how long were you a patient there?	
Date of your last dental exam	
Date of your last cleaning	

Personal History

Please answer the following questions	
Are any teeth currently sensitive to biting, sweets, hot, or cold?	
Do you wear, or have you ever worn a bite appliance? Either for clenching at night (a night guard) or for sleep apnea?	
Does the amount of saliva in your mouth seem too little or do you find yourself with a dry mouth often?	
Have you ever noticed a consistently unpleasant taste or odor in your mouth?	

Dental Structural History

Please answer the following questions	
Do your gums bleed when brushing or flossing?	
Have you ever been treated for or been told you have gum disease?	
Have you ever had braces, orthodontic treatment or spacers, or had a "bite adjustment?"	
Do you have problems with your jaw joint? (TMD, popping, clicking, deviating from side to side when opening or closing?)	
Is it often difficult to open wide?	

Patient's signature: Date:

General Dentist's signature: Date: