PATIENT DENTAL HISTORY

YES NO Are you having any dental problems or discomfort?

YES NO Would you like to make any changes to the shape or color of your teeth?

YES NO Do your gums bleed?

YES NO Are your teeth sensitive to cold, hot, air, pressure or sweets?

YES NO Do you clench or grind your teeth during the night or day?

YES NO Have you experienced any pain problems with your jaw/TMJ?

YES NO Do you have frequent headaches, neck and shoulder pain?

YES NO Do you snore?

YES NO Do you have dry mouth?

YES NO Have you ever had orthodontic treatment? (braces)

YES NO Have you ever had prolonged bleeding after extractions?

YES NO Have you ever had periodontal (gum) treatments? When?____________

YES NO Have you ever had gum grafts?

YES NO Have you ever had an in-depth oral cancer screening (i.e. Vizilite)?

NOTES/COMMENTS____

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By signing I certify that I have read and understand the above information and have answered to the best of my knowledge

Signature:____ Date:________________