Patient Name: ______________________________

DENTAL HEALTH HISTORY

The information you provide is important for your dental health. If there have been any changes in your health, ***please tell us***. If you have any questions, do not hesitate to ask. Please answer ***Yes or No*** to the following questions:

	Yes	No		Yes	No
Are you having discomfort?			Are your teeth turning yellow or loosing brightness?		
Any sensitivity to hot, cold, sweets, chewing?			Do you smoke?		
Does dental treatment make you nervous?			Do you drink coffee or tea?		
Have you experienced any of the following problems?			**If I could change my smile I would make my teeth:**		
· Snoring Problem			· Whiter		
· Bleeding Gums			· Close Space		
· Bad Breath			· Replace stained front filling		
· Grinding teeth			· Change Silver filling to White		
· Mouth Guard for athletes			· Repair Chipped teeth		
			· Other		
Do you have difficulty brushing your teeth due to the following?					
· Arthritis			Do you take fluoride supplement?		
· Difficulty in reaching back teeth			Do you prefer to save your teeth?		
· Uncontrolled hand movement			Have you had a special coating applied to your back teeth to protect from tooth decay?		
• Other: ______________					
			Date of last cleaning? ___/___/___		
Have you ever had Periodontal Therapy done? When??					
Denture and Partial Patients:					
Do you wear a Denture/Partial?			If you wear a partial, did you ever break a Clasp?		
How old is your Denture/Partial? ________			Do you use Denture Cleaner?		
Have you relined your Dentures before?			Do you use any product to prevent denture odor?		
Does your denture cause any irritation/soreness?			Are your dentures loose?		
Have your dentures ever broken or cracked?			Do you use any denture adhesive?		

Please explain reason for your visit to our office today ______________________________

Do you require pre-medication? ________

How many times a day do you brush? ____________ **How many times a week do you floss?** ____________

What type of toothbrush bristles do you use? Soft________ **Medium** ________ **Hard**________

How would you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)