**Dental History**

Name

Date

Reason for today’s visit?

When was your last dental visit?

Date of last dental X-rays?

Check if you have had problems with any of the following:

[ ]  Bad breath [ ]  Grinding teeth

[ ]  Sensitivity to hot [ ]  Bleeding gums

[ ]  Loose teeth or broken fillings [ ]  Sensitivity to sweets

[ ]  Clicking or popping jaw [ ]  Periodontal treatment

[ ]  Sensitivity when biting [ ]  Sensitivity to cold

[ ]  Food collection between teeth [ ]  Sores or growth in mouth

How often do you brush

How often do you floss

Texture of your brush [ ]  Soft [ ] Medium [ ]  Hard [ ]  Nylon [ ] Natural

Are you familiar with the term “preventive dentistry”? [ ]  Yes [ ]  No

Please add anything else you feel is important for us to know: