**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: