Patient Name: _____

Dental History Questionnaire

Please take the time to complete the following questions so that we may better meet your dental needs.

Other than cleaning and exam, what is your primary reason for visiting today?

_____

Would you be interested in a free consultation exam to discuss possible treatment options to improve your smile?	Yes	No
Are you interested in whitening your teeth?	Yes	No
Do you use tobacco?	Yes	No
When was your last dental cleaning?	_____	

Are any specific teeth sensitive to:

Hot?	Yes	No
Cold?	Yes	No
Biting/Chewing?	Yes	No

Please list which teeth are **currently** sensitive (upper left molar, lower front etc.)_____

Have you ever had in the **past** or do you **currently** have:

Orthodontic Treatment?	Yes	No
Nightguard made by a dentist?	Yes	No
A gum infection or treatment?	Yes	No
Oral Surgery?	Yes	No
Serious injury to your teeth, jaw, or gums?	Yes	No
Oral Cancer?	Yes	No

Bruxism is a very common subconscious habit of clinching and grinding one's teeth that leads to damage of teeth, their nerves, and supporting tissues (gums, jaws, muscles).

Do you clinch and/or grind your teeth?	Yes	No
Have you ever had a cracked or chipped tooth?	Yes	No
Have you ever had prolonged sensitivity following dental fillings and/or crowns?	Yes	No
Are your teeth ever sensitive without an identifiable reason?	Yes	No
Do you have TMJ disorder or jaw muscle pain?	Yes	No

Whom may we thank for referring you? _____