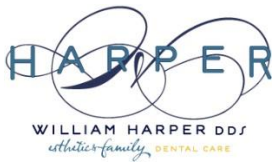

Dental History

Date _____ Do you have any current dental problems? _____

1.) Date of last complete dental examination. _____

2.) Are your teeth sensitive? _____

3.) Do your gums bleed or hurt? _____

4.) Have you noticed any loose teeth or change in your bite? _____

5.) Have you noticed any mouth odors or bad tastes? _____

6.) Does food tend to become caught between your teeth? _____

7.) Do you clench or grind your teeth? _____

8.) Have you ever had Orthodontic treatment? _____

9.) Have you ever seen a Periodontist or gum specialist? _____

10.) Has your bite ever been adjusted? _____

11.) Do you have clicking or popping in your jaw? _____

12.) Do you have difficulty opening or closing your mouth? _____

13.) Have you ever been told you have a TMJ problem? _____

14.) Do you get frequent headaches? _____

15.) Would you like to keep your teeth all your life? _____

16.) Do you feel nervous about having dental treatment? Yes No
If yes, what is your biggest concern? _____
_____

17.) Have you ever had an upsetting dental experience? Yes No
If yes, please describe. _____
_____

18.) Are you happy with the appearance of your teeth? Yes No
If no, what would you like to change? _____
_____

19.) Please circle the phrase that BEST describes your dental goals.

Prevent problems

Treatment only when decay tooth damage, abscess, or other disease develops

Treatment only when something hurts