FIRST LIGHT | DENTAL OF COASTAL VIRGINIA

Dental History

Patient's Name: ________________________ Date:______________________

1) Do you have any current dental problems? ____
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 your 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