Dental History Form

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DENTAL HISTORY FORM

PATIENT NAME: **(PREFERRED):** **DATE:**

Please describe the primary reason for your visit (concerns):

1. _____

2. _____

3. _____

4. **How long has this been going on and what would you like done?**

_____

_____

5. **If you could rate your smile from 1 - 10, what would it be?** _____

6. **Would you like to improve your smile?** Y N **How?** _____

_____

Have you ever suffered from, or been told you may have any of the following?

7. Gum disease	Y	N	11. Sleep:Snoring/Stop Breathing	Y	N
8. Bruxism or Grinding	Y	N	12. Bad Breath	Y	N
9. Jaw pain or TMJ	Y	N	13. Headaches or Migraines	Y	N
10. Dental pain	Y	N	14. Tooth Sensitivity to Hot/Cold	Y	N

DOCTOR'S NOTES: _____