**Date:** ____________

***Dental History***

**Reason for today's visit?** ____________

**Former Dentist:** ____________ **City/State:** ____________

**Date of last dental visit** ____________ **Date of last dental x-rays:** ____________

***Please select "yes" or "no" to indicate if you have/ had any of the fol owing:***

| | Question | Yes | No |
|---|---|---|---|
| 1. | **Bad breath?** | Yes ☐ | No ☐ |
| 2. | **Bleeding gums?** | Yes ☐ | No ☐ |
| 3. | **Blisters on lips or mouth?** | Yes ☐ | No ☐ |
| 4. | **Chew on one side of month?** | Yes ☐ | No ☐ |
| 5. | **Cigarette, pipe or cigar smoking?** | Yes ☐ | No ☐ |
| 6. | **Clicking or popping jaw?** | Yes ☐ | No ☐ |
| 7. | **Dry mouth?** | Yes ☐ | No ☐ |
| 8. | **Fingernail biting?** | Yes ☐ | No ☐ |
| 9. | **Food collection between the teeth?** | Yes ☐ | No ☐ |
| 10. | **Grinding of teeth?** | Yes ☐ | No ☐ |
| 11. | **Gums swollen or tender?** | Yes ☐ | No ☐ |
| 12. | **Jaw pain or discomfort?** | Yes ☐ | No ☐ |
| 13. | **Loose teeth or broken filling?** | Yes ☐ | No ☐ |
| 14. | **Mouth breathing?** | Yes ☐ | No ☐ |
| 15. | **History of orthodontic treatment?** | Yes ☐ | No ☐ |
| 16. | **History of root canal treatment?** | Yes ☐ | No ☐ |
| 17. | **History of periodontal treatment?** | Yes ☐ | No ☐ |
| 18. | **Sensitivity to cold, hot, sweets, biting?** | Yes ☐ | No ☐ |
| 19. | **Are you happy with your smile?** | Yes ☐ | No ☐ |
| 20. | **How often do you brush?** | Yes ☐ | No ☐ |
| 21. | **Is there anything you would like to change about your smile?** | Yes ☐ | No ☐ |
| 22. | **Have you ever had cosmetic dentistry?** | Yes ☐ | No ☐ |
| 23. | **Have you ever had botox treatments?** | Yes ☐ | No ☐ |
| 24. | **Have you ever had juvederm treatments?** | Yes ☐ | No ☐ |
| 25. | **Have you ever had botox treatments?** | Yes ☐ | No ☐ |
| 26. | **Have you ever had dermal fillers?** | Yes ☐ | No ☐ |

**Signature** ____________ **Date** ____________