Steven E. Smith DDS MAGD

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Dental History

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Please take a moment to let us know about your dental history so we may serve you more effectively.

What is the reason for your dental visit today?

_____

_____

When was your last visit to the dentist (if to a different office)?

_____

_____

When was your last dental cleaning?

_____

_____

When was your last full set of xrays?

_____

_____

Prior Dentist's name, address, & phone number:

_____

_____

How frequently do you brush your teeth?

◯ 3 (+) a day ◯ Twice a day ◯ Once a day ◯ Weekly ◯ Seldom

How frequently do you floss your teeth?

◯ 1 (+) a day ◯ 2 - 6 weekly ◯ 1 - 6 monthly ◯ Seldom ◯ Never

Do you use a mouthrinse? ◯ Yes ◯ No

If yes, please list brand

_____

_____

Do you have a past dental history of any of the following?

- ☐ Orthodontics
- ☐ Oral Surgery
- ☐ Periodontal Treatment
- ☐ Loose Teeth
- ☐ Painful, Swollen or bleeding gums
- ☐ Bite Adjusted
- ☐ Nightguard of other intraoral appliance
- ☐ Dental Implants

If any of the previous questions are marked, please explain:

Do you have a history of any TMJ problems?

- ☐ Jaw Clicking
- ☐ Jaw Joint Pain
- ☐ Ear Pain
- ☐ Jaw Muscle Pain
- ☐ Difficulty Opening or Closing
- ☐ Difficulty Chewing
- ☐ Regular Headaches
- ☐ Neck or Shoulder Pain

If any of the previous questions are marked, please explain:

Do you have any of the following habits?

- ☐ Clenching or Grinding of the Teeth
- ☐ Lip or Cheek Chewing
- ☐ Chewing your fingernails
- ☐ Holding Foreign Objects with your Teeth
- ☐ Mouth Breathing
- ☐ Regular snacking between meals
- ☐ Drinking soda or other sweetened drinks on a regular basis

If any of the previous questions are marked, please explain:

How do you feel about your teeth?

- ☐ I want to keep my teeth
- ☐ I'm happy with the appearance of my teeth
- ☐ I want to change the appearance of my teeth (color, shape, etc)

If you could change anything about your mouth, teeth, or smile, what would it be?

Have you had any difficulties with dental treatment in the past?

- ☐ Gagging
- ☐ Upsetting Experience

If any of the previous questions are marked, please explain:

Response Date: _____