**Dental History Form**

Patient name: ………………………………………………… Date:……………

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

1…………………………………………………………………………………………………………………………

2…………………………………………………………………………………………………………………………

3…………………………………………………………………………………………………………………………

When was the last time you saw a dentist? …………

If you could rate your smile from 1-10 what would it be? ……………

Would you like to improve your smile? Y…….. N…….

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

Gum disease Y N Malocclusion Y N

Bruxism or grinding Y N Bad breath Y N

Jaw pain or TMJ Y N Headaches or migraines Y N

Dental pain Y N Tooth sensitivity to hot/cold Y N

Doctor’s notes ………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………