



1401 S. Arlington Heights Rd. Suite One
Arlington Heights, Illinois 60005
847-259-7789

Dental History

Yes No Are you presently having any dental problems?
If yes, please describe _____
When was your last dental visit? _____

Yes No Have you had any problems or upsetting experience associated with any previous dental treatment?
What is your reaction to having dental work done? (Circle one:)
Dread it. Worry about it. Don't mind it.

Yes No Have you ever experienced problems with dental anesthetics?

Yes No Have you had orthodontic treatment (braces)?

Yes No Have you lost any permanent teeth (including wisdom)?

Yes No If yes, were missing teeth replaced?

Yes No Do your gums bleed when you brush your teeth?

Yes No Does food catch between your teeth?

Yes No Do any teeth feel loose?

Yes No Do you have any unpleasant odor or taste in your mouth?

Yes No Have you ever been treated for periodontal (gum) disease?

Are any teeth sensitive?

Yes No To heat

Yes No To cold

Yes No To sweets

Yes No When chewing

Yes No Do you clench or grind your teeth while awake or asleep?

Yes No Do you have chronic headaches or neck and shoulder pain?

Yes No Do you now, or have you ever had, pain in your jaw joint or the sides of your face (in and around the ears)?

Yes No Do you have a clicking jaw joint or have you ever experienced an inability to move your jaw or open your mouth widely?

Yes No Have you ever had your bite adjusted?

Yes No Have you ever worn a night guard or any other appliance?

If you could wave a magic wand and change your smile, what would you want to look like? _____

What concerns, if any, do you have about today's visit? _____

By what name may we call you? _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature

Date

UPDATE REVIEW

Date Pt's Init.

