**Dental History**

Date of last dental exam/cleaning and x-rays ____________________________________________

Name of previous dentist ___________________________________________________________

Reason for leaving __________________________________________________________________

Check yes or no if you have had any of the symptoms listed below

Y  N  Are you having any discomfort at this time? ______________________________________

Y  N  Sensitive teeth _________________________________________________________________

Y  N  Bleeding gums _________________________________________________________________

Y  N  Clicking or popping jaw, pain, TMJ, TMD __________________________________________

Y  N  Dry mouth ______________________________________________________________________

Y  N  Do you clench or grind your teeth _________________________________________________

Y  N  Have you ever had any serious or difficult problems associated with any previous dental treatment?
If yes, please explain _________________________________________________________________

Other ______________________________________________________________________________

How many times each day do you brush your teeth? _____ How many times each week do you floss? _____

Do you use an electric tooth brush? ______ If yes, which one? _______________________________

**Periodontal History**

Y  N  Know

Y  N  Don’t

Y  N  Have you ever been told you have periodontal disease?

Y  N  Has anyone in your family had/have periodontal disease?

Y  N  Have you ever had periodontal surgery?

How would you rate your dental health on a scale of 1 (poor) to 10 (excellent) ______

How would you rate your overall health on a scale 1 (poor) to 10 (excellent) ______

Are you happy with the appearance of your smile?  Y  N  Would you like whiter teeth?  Y  N

Have you whitened your teeth previously?  Y  N  Are you interested in discussing cosmetic dentistry with us?  Y  N

What is most important to you about your dentist? _______________________________________

What is most important to you about your dental office/team? _______________________________

Is there anything else you would like us to know about your previous dental experiences?
__________________________________________________________________________________

Is there anything we can do to make your dental visits easier for you?_____________________

__________________________________________________________________________________

Do you struggle to have a good night sleep, or know you have Sleep Apnea?