
**Dental History**

1. Date of last dental exam:_____

2. Previous Dentist's Name: _____

Phone Number _____

3. Are you having tooth or gum pain at this time? Yes No

4. Do you feel nervous about having dental treatment? Yes No

5. Have you ever had a bad experience in a dental office? Yes No

6. Do your gums bleed when brushing / flossing? Yes No

7. Have you ever seen a periodontist? Yes No

8. Have you ever had a "deep cleaning" (Scaling and Root Planing)? Yes No

**Do you have any of the following dental concerns**:

Clicking in jaw joint Yes No

Sensitivity to: Hot Cold Sweets Biting

Pain in or around your ears Yes No

Difficulty opening or closing Yes No

Difficulty chewing Yes No

History of trauma to jaw or face Yes No

Diagnosis of TMJ/TMD Yes No

**I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate.**

Signature: _____ Date_____/_____/_____