

DENTAL HISTORY

Previous Dentist: _____ Phone: _____

How often do you brush your teeth? _____ Floss? _____

Do your gums ever bleed? Yes / No

Do you experience bad breath/unpleasant tastes? Yes / No

Have you ever been diagnosed with periodontal disease? Yes / No

 Did you receive treatment for this? Yes / No

Do you breathe through your mouth during the day or night? Yes / No

Are your teeth sensitive to cold, heat, sweets, or pressure? Yes / No

Do you grind or clench your teeth? Night / Day Yes / No

Does your jaw pop, click, ache, or feel tired? TMJ fatigue / Pain? Yes / No

Have you ever had an injury to your face, neck, or jaw? Yes / No

Do you have headaches or excessive tension across your forehead
or temple area? Yes / No

Have you ever had orthodontic treatment? Yes / No

Do you smoke or chew tobacco? Yes / No

Do you have problems with snoring? Sleep Apnea? Yes / No

Have you ever had an unfavorable dental experience? Yes / No

Are you dissatisfied with the appearance of your teeth? Yes / No

To the best of my knowledge, all of the above information is true and correct. If I ever have any changes in my health or medication, I will inform Gundersen Dental Care at the next appointment.

Signature: _____ Date: _____

Parent or Guardian: _____ Date: _____