

Dental History

Reason for visit _____

Date of last dental visit _____

Date of last dental X-rays _____

How often do you floss _____

How often do you brush _____

Bad Breath _____

Bleeding, Red, Swollen Gums _____

Broken/Loose teeth or fillings _____

Clicking or popping jaw _____

Grinding teeth _____

Pain around ear/side of face _____

Sores/Blisters in mouth _____

List any other dental concerns/pain _____