To save time, complete this at your leisure and bring with you to the examination appointment.

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Dental History

Name of dentist:: _____ City: _____

Month/Year of last dental examination: /
M Y

Please check yes or no for the following

Y ☐ N ☐ Previous orthodontic treatment?
Y ☐ N ☐ Frequent or severe tooth decay?
Y ☐ N ☐ History of gum problems or treatment?
Y ☐ N ☐ Fear of dentistry?
Y ☐ N ☐ Current dental pain?
Y ☐ N ☐ Permanent teeth extracted?
Y ☐ N ☐ Congenital absence of teeth?
Y ☐ N ☐ Clenching or grinding habits?

Y ☐ N ☐ Clicking or other noise in jaw joints?
Y ☐ N ☐ Pain in jaw joints?
Y ☐ N ☐ Thumb, finger or lip sucking habit now?
Y ☐ N ☐ History of such habits?
Y ☐ N ☐ Pain in chewing muscles or face?
Y ☐ N ☐ History of injury to teeth or jaws?
If yes to injury please describe below:

Dental injury: (When and what?)

Treatment:
Who treated?
What treatment?

Is this visit for a second opinion? Y ☐ N ☐

If yes, are there any records (x-rays or dental models) that we can request? Y ☐ N ☐

If yes where? _____

What can we help you with? (Check all that apply.)

☐ Crowded or misaligned teeth
☐ Excess space between teeth
☐ Protrusion of teeth
☐ Problem with jaw size or position
☐ Appearance of front teeth
☐ Bite problems

☐ Dentist suggested orthodontic screening
☐ Head off a developing problem
☐ Self-consciousness about appearance of teeth
☐ Dentist needs tooth movement to help with restorative plan.

☐ Other: _____

Patient's name and age: _____

_____ _____
Signature: Signature of parent or guardian required for patient less than 18 years of age. Date:

Thank you for helping us to get to know you.