

## Health History Form

For the following questions, please (x) whichever applies, your answers are for our records only and will keep it confidential in accordance with applicable laws. Please note that during your initial visit you will be asked some questions about your response to this questionnaire and there may be additional questions concerning your health. This information is Vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

### DENTAL INFORMATION

	Yes	No
Do your gums bleed when you brush?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had periodontal treatment	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had orthodontic treatment	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to hot, cold, pressure	<input type="checkbox"/>	<input type="checkbox"/>
Do you have earaches or neck pains?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have teeth grinding/ Clenching	<input type="checkbox"/>	<input type="checkbox"/>
Bad Breath	<input type="checkbox"/>	<input type="checkbox"/>
Stained Teeth	<input type="checkbox"/>	<input type="checkbox"/>
Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ/TMD)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Date of your last dental Exam: \_\_\_\_\_ Date of last X-rays: \_\_\_\_\_

How often do you brush? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

How do you feel about the appearance of your teeth? \_\_\_\_\_

Would you like your teeth whiter? Yes  No

What would you like to change about your smile? \_\_\_\_\_

What are your dental priorities? \_\_\_\_\_

\_\_\_\_\_  
(e.g.: apprentice, dental health, financial considerations, etc.)