Dental History Form

Page 1

Dental Information

Patient's First Name *

Patient's Last Name *

Reason for today's visit

Are you in pain? *

- Yes
- No

Please indicate any of the following problems by selecting the corresponding box:

- Discomfort, clicking, or popping in jaw
- Lost/broken filling(s)
- Stained teeth
- Difficulty closing jaw
- Red, swollen, or bleeding gums
- Teeth grinding/ clenching
- Locking jaw
- Difficulty opening jaw
- A removable dental appliance
- Ringing in ears
- Bad breath
- Loose/shifting teeth
- Blisters/sores in or around the mouth
- Broken / chipped tooth
- Burning tongue / lips
- Gum Disease
- Prolonged bleeding from an injury/extraction
- Toothache
- Swelling / lumps in mouth
- Recent infections or sore throat
- Food caught between teeth
- Other

My teeth are sensitive to:

- Hot
- Cold
- Sweets
- Biting

Signature *

Date

10/08/2025