North Seattle Smiles

DENTAL HISTORY

Patient Name: _____ Date: _____

1. What is your primary reason for seeking dental care?

_____

2. When was your approximate date of your last dental visit?

_____

3. When was the approximate date of your last cleaning?

_____

4. Have you been satisfied with your past dentistry?

_____

5. Have you ever had a negative dental experience in the past? ☐Yes ☐ No if yes, please explain.

_____

6. Has the dental fear/anxiety prevented you from regular care? ☐Yes ☐ No if yes, please explain.

_____

7. Have you ever had nitrous oxide for past dental treatments? ☐Yes ☐ No

How many times daily do you brush your teeth? _____

How many times daily do you floss your teeth? _____

Do your gums feel tender and/or bleed easily? ☐ yes ☐ no

Have you had any periodontal treatments? ☐ yes ☐ no if yes, when? _____
(Deep cleanings, gum grafting, perio laser therapy etc.)

Have you had orthodontic treatment? ☐ yes ☐ no if yes, when? _____
(Braces, Invisalign/ClearCorrect/Candid aligners, etc.)

Have you had any oral pathology/oral biopsy in the past? ☐ yes ☐ no if yes, please explain _____

Have you had problems with teeth or fillings breaking? ☐ yes ☐ no if yes, please explain _____

Are you happy with the appearance of your teeth? ☐ yes ☐ no if no, please explain _____

Are your teeth sensitive to temperature ☐ yes ☐ no

Are your teeth sensitive to pressure? ☐ yes ☐ no

Have you had trauma to the head or teeth in the past? ☐ yes ☐ no if yes, please explain _____

Do you gag easily during dental visits? ☐ yes ☐ no

Do you notice that your mouth is dry? ☐ yes ☐ no

Do you have pain in your jaw joints? ☐ yes ☐ no

Do you grind or clench your teeth? ☐ yes ☐ no

Do you wear a night guard? ☐ yes ☐ no