MARR · FAMILY · DENTISTRY

Dental History

The reason for your visit today_____

Date of last: Dental visit_____ Dental Cleaning_____ X-rays_____

Previous Dentist's name_____

How often do you brush your teeth?_____ How often do you floss?_____

What other dental aids do you use? (waterpick, toothpick, etc.)_____

If you have any dental problems now, please describe_____

Have you ever had or experienced…?

Orthodontic Treatment	Yes/No	Oral Surgery	Yes/No
Periodontal Treatment	Yes/No	Bite adjustment	Yes/No
Bite plate or mouth guard	Yes/No	Clenching/grinding teeth	Yes/No
Clicking or popping of your jaw	Yes/No	Pain in your jaw joint	Yes/No
Difficulty opening/closing mouth	Yes/No	Head, neck, or shoulder aches	Yes/No
Sleepy or fatigued during the day	Yes/No	Do you snore?	Yes/No

Serious Injury to mouth or head Yes/No

If yes, please describe (include cause)_____

Is there anything else you would like us to know about your dental history or treatment?

_____

My signature below indicates that you have my permission to request information that may aid in my treatment from Health Care Providers, and they have my permission to release this information.

Signature_____ Date_____