



## Dental History

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NAME: \_\_\_\_\_

1. Who is your general dentist? \_\_\_\_\_
2. How often do you get your teeth cleaned by a dentist or dental hygienist? \_\_\_\_\_
3. When was your last dental cleaning? \_\_\_\_\_
4. How often do you brush your teeth? \_\_\_\_\_
5. How often do you floss your teeth? \_\_\_\_\_
6. Have you ever had a “deep cleaning” or “scaling and root planing”?  Yes  No
7. Have you ever been treated for periodontal disease or had periodontal surgery?  Yes  No
8. Do you clench or grind your teeth?  Yes  No
9. Do you wear a bite guard?  Yes  No
10. Have you ever experienced jaw popping/clicking or pain (TMD)?  Yes  No
11. Do you have any oral habits (nail biting, cheek biting, aggressive tooth brushing, other)  Yes  No

If yes, explain: \_\_\_\_\_

12. Do you get cold sores, fever blisters or other mouth sores?  Yes  No
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