

## CONFIDENTIAL DENTAL HISTORY FORM

Why have you come to the dentist today? \_\_\_\_\_

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Your current dental health is: Good Fair Poor

Are you currently in pain? Yes No

Have you ever had a serious/ difficult problem associated with any previous dental work? Yes No

Do you now, or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? Yes No

Do any of your teeth hurt when you bite or chew? Yes No

Are any of your teeth sensitive to hot or cold? Yes No

Do you like your smile? Yes No

Are you satisfied with the shape and/or shade of your teeth?  
Yes No

Do your gums ever bleed? Yes No

How many times per week do you floss? \_\_\_\_\_  
Per day do you brush? \_\_\_\_\_

Have you ever been under the care of a periodontist? Yes No

Do you smoke? Yes No  
How much? \_\_\_\_\_

Payment is due in full at the time of treatment unless prior arrangements have been made regarding payment plans or insurance.

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

I understand that the information provided is correct to the best of my knowledge. I authorize the dental staff to perform necessary dental services, with my informed consent, needed during diagnosis and treatment.

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Signature

Date

