



3844 Kennett Pike  
Greenville, DE 19807  
(302) 575-0100

Name \_\_\_\_\_ Date \_\_\_\_\_

## Dental History Form

Welcome! Thank you for selecting our dental healthcare team! To help meet your needs, please answer the following questions that are designed to open a discussion of your dental concerns. If you need any assistance, please ask us, we will be happy to help.

Describe your current dental problem(s) or concern(s):

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Are any teeth currently sensitive to heat? \_\_\_\_ cold? \_\_\_\_ sweets? \_\_\_\_ biting? \_\_\_\_

Who was your last dentist? \_\_\_\_\_ Last dental visit? \_\_\_\_\_

Why did you leave your last dentist? \_\_\_\_\_

Do you have access to recent x-rays? \_\_\_\_\_

Are you apprehensive about dental treatment? \_\_\_\_\_

How often do you floss? \_\_\_\_\_ How is your breath? \_\_\_\_\_

Do your gums ever bleed? \_\_\_\_\_ Are your gums red? \_\_\_\_\_

Have you had periodontal treatment? \_\_\_\_\_

Any broken teeth? \_\_\_\_\_ Any loose fillings? \_\_\_\_\_

Any trouble with your jaw? \_\_\_\_\_

Do you clench your teeth during the day? \_\_\_\_ Do you grind your teeth at night? \_\_\_\_

Have you ever been told that you grind your teeth? \_\_\_\_ Does your jaw pop or click? \_\_\_\_

Are there any sores or growths in your mouth? \_\_\_\_\_

What is your long range dental plan? \_\_\_\_\_

If you could change the appearance of your teeth, what would you change? \_\_\_\_\_

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What would satisfy you as a patient? \_\_\_\_\_