Dental Health History

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HANSEN
FAMILY DENTAL

Dental Health History

Patient First Name *

Patient Last Name *

Last Dental Exam

Last Dental X-Ray(s)

How often do you have your teeth cleaned?

○ 3 mos ○ 4 mos ○ 6 mos ○ 1 year or longer

What are your present dental concerns, if any? Check any that apply:

- ☐ Bleeding Gums
- ☐ Crooked Teeth
- ☐ Cosmetic
- ☐ Loose Teeth
- ☐ Bad Breath
- ☐ Food Trapping
- ☐ Sensitive Teeth
- ☐ Toothache
- ☐ Loose Dentures
- ☐ Missing Teeth/Spaces
- ☐ Want Whiter Teeth
- ☐ Other

Are you apprehensive about dental treatment?

○ Yes ○ No ○ Maybe/Not Sure

Have you had problems with previous dental visits?

○ Yes ○ No ○ Maybe/Not Sure

Does food catch between your teeth?

○ Yes ○ No ○ Maybe/Not Sure

Are your teeth sensitive?

○ Yes ○ No ○ Maybe/Not Sure

Do you clench or grind your teeth?

○ Yes ○ No ○ Maybe/Not Sure

Frequent headaches and/or jaw pain?

○ Yes ○ No ○ Maybe/Not Sure

Have you had or currently in orthodontic treatment (braces/clear aligners)?

○ Yes ○ No ○ Maybe/Not Sure

Using a partial or denture?

○ Yes ○ No ○ Maybe/Not Sure

How often do you brush?

How often do you floss?

Questions? Comments? Concerns?