ORAL CONSTRUX

Dental History

Patient name: _____

What is the reason for your dental visit today? _____

_____

Do you currently have any teeth that are sensitive?

Yes ☐ No ☐ If yes, please explain. _____

_____

_____

When was the last time you saw a dentist? _____

When was your last professional cleaning? _____

How often do you brush your teeth? _____

How often do you floss your teeth? _____

	Yes	No
Have you ever been treated for periodontal disease (gum disease)?	☐	☐
Do you feel that you can chew well with your teeth?	☐	☐
Do you grind or clench your teeth?	☐	☐
Do you ever have jaw pain or jaw muscle soreness?	☐	☐
Have you ever worn a nightguard or been told that you should?	☐	☐
Do you like the way your smile looks?	☐	☐
Do you like the color of your teeth?	☐	☐
Do you have any teeth or restorations that you are unhappy with?	☐	☐
Would you like to discuss esthetic improvements that can be made to your smile?	☐	☐