

575 Fallbrook BLVD #107  
Lincoln, NE 68521  
(402) 467-0007



Name: \_\_\_\_\_

Date: \_\_\_\_\_

### DENTAL HISTORY

Please describe your chief oral complaint:

\_\_\_\_\_  
\_\_\_\_\_

Are your teeth sensitive to:	YES	NO
Heat?.....	_____	_____
Cold?.....	_____	_____
Sweets?.....	_____	_____
Chewing?.....	_____	_____
Do you have any food traps?.....	_____	_____
Do your gums ever feel tender or swollen?.....	_____	_____
Do your gums bleed when brushing?.....	_____	_____
Do you have any teeth that feel loose?.....	_____	_____
Have you been treated for periodontal disease?.....	_____	_____
Do you use dental floss?.....	_____	_____
Have you had any injuries to your face or jaw?.....	_____	_____
Have you ever had your teeth straightened/braces?.....	_____	_____
Do you clench or grind your teeth?.....	_____	_____
Do you strike some teeth before others when closing?.....	_____	_____
Have you ever had your bite adjusted?.....	_____	_____
Do your jaws ever feel tired or ache?.....	_____	_____
Can you chew comfortably?.....	_____	_____
Have you had a complete dental exam including full mouth x-rays in the past 3 years?.....	_____	_____
Do you have your teeth cleaned regularly?.....	_____	_____
Do you have all of your natural teeth?.....	_____	_____
Would you like to keep your natural teeth?.....	_____	_____
Are missing teeth replaced?.....	_____	_____
Do you like the appearance of your smile?.....	_____	_____
Do you consider yourself a nervous patient?.....	_____	_____
Have you ever had a bad dental experience?.....	_____	_____
Have you ever had issues with local anesthetics?.....	_____	_____

Physician's Name \_\_\_\_\_ Phone # \_\_\_\_\_

Last visit to physician \_\_\_\_/\_\_\_\_/\_\_\_\_ Last complete physical \_\_\_\_/\_\_\_\_/\_\_\_\_

When was your last dental visit? \_\_\_\_/\_\_\_\_/\_\_\_\_ Last Cleaning \_\_\_\_/\_\_\_\_/\_\_\_\_

What was done at that visit? \_\_\_\_\_

Where was it done? \_\_\_\_\_

If you could change your teeth/smile, how would you? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Please complete the reverse side also---->