House Dental
3133 E Camelback Rd #190, Phoenix, AZ 85016, USA
(602) 957 4576
www.housedental.com/

DENTAL HISTORY
| DOB:

General Information

Who was your previous Dentist and how long were you a patient there?	
Date of your last dental exam	
Date of your last cleaning	
Do you have any immediate concerns you'd like us to address?	

Office Relationship

What do you value most in your dental visits?	
Is there anything you prefer during your visits to make you more comfortable during your time with us?	
On a scale from 1-5, 5 being most terrified, are you fearful of dental treatment?	

Personal History

Please answer the following questions	
Are you concerned about the appearance of your teeth?	
Are you interested in improving your smile?	
Have you had any cavities within the past 2 years?	
Are any teeth currently sensitive to biting, sweets, hot, or cold?	
Do you avoid or have difficulty chewing or biting heavily any hard foods?	
Do you have any problems sleeping, wake up with a headache or with sore or sensitive teeth?	
Do you clench your teeth in the daytime?	
Do you wear, or have you ever worn a bite appliance? Either for clenching at night (a night guard) or for sleep apnea?	
Do you bite your nails, chew gum or on pens, hold nails with your teeth, or any other oral habits?	
Does the amount of saliva in your mouth seem too little or do you find yourself with a dry mouth often?	
Have you ever noticed a consistently unpleasant taste or odor in your mouth?	

Dental Structural History

Please answer the following questions	
Do your gums bleed when brushing or flossing?	
Is brushing or flossing typically painful?	
Have you ever experienced or been told you have gum recession?	
Have you ever been treated for or been told you have gum disease?	
Have you had any teeth removed for braces or otherwise?	
Do you know of any missing teeth or teeth that have never developed?	
Have you ever had braces, orthodontic treatment or spacers, or had a "bite adjustment?"	

Are your teeth becoming more crowded, overlapped, or "crooked?"	
Are your teeth developing spaces?	
Do you frequently get food caught between any teeth?	
Have you noticed your teeth becoming shorter, thinner, or flatter over the years?	
Do you have problems with your jaw joint? (TMD, popping, clicking, deviating from side to side when opening or closing?)	
Is it often difficult to open wide?	
Do you have more than one bite? Or do you notice shifting your jaw around to make your teeth fit together?	

Patient's signature: Date:

Doctor's signature: Date: