



## *Dental History*

Purpose of visit? \_\_\_\_\_

\_\_\_\_\_

*Please circle the appropriate answer:*

Have you lost any teeth or have any teeth been removed? Yes or No

Have they been replaced? Yes or No

Are you unhappy with the replacement? Yes or No

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Have you ever had any problems/complications with previous dental treatment?

Yes or No

If yes, please explain: \_\_\_\_\_

Do you grind your teeth? Yes or No

Are any of your teeth sensitive to:       Hot    Cold    Sweets    Pressure

Do your gums bleed or hurt? Yes or No

How often do you brush your teeth? \_\_\_\_\_

Do you use dental floss? Yes or No

How often? \_\_\_\_\_

Are any of your teeth loose, tipped, shifted or chipped? Yes or No

Are you unhappy with the appearance of your teeth? Yes or No

Have you ever had gum treatment or surgery? Yes or No

When? \_\_\_\_\_

Why do you think dental implants are right for you?

\_\_\_\_\_