Pineview Family Dental
Dental Health History

First and Last Name_____ Date _____

Are you apprehensive about dental treatment? *
Yes No
Have you had problems with dental treatment in the past? *
Yes No
Prior to coming to our office, how often were you seeing a hygienist for dental cleanings?
3mos 4mos 6mos _____
Have you ever had Scaling & Root planing? *
Yes No Unsure
When was your last dental visit?
Do you gag easily? *
Yes No
Do you wear partials or dentures? *
Yes No
Does food catch between your teeth? *
Yes No
Do your gums bleed when brushing or flossing? *
Yes No
Are your teeth sensitive to hot/cold temperatures, sweet or sour foods? *
Yes No
Are you happy with the appearance of your teeth? *
Yes No
Do you prefer to save your teeth? *
Yes No
How often do you brush?

How often do you floss?

Does your jaw make clicking or popping noises upon opening or closing? *
Yes No

Do you grind your teeth? *
Yes No
Do you clench your teeth? *
Yes No
Do suffer from earaches or pain in your jaw joint? *
Yes No
Do you currently or have you ever worn a mouth guard? *
Yes No
Have you ever been diagnosed with TMJ or TMD (Temporomandibular (jaw) disorder)? *
Yes No
Is there anything else related to your teeth we should be aware of? *