SUNRISE
SMILE DESIGN

DENTAL HISTORY

Date: ___/___/_____ Patient Name: _____ Birth Date: ___/___/_____

Previous Dentist: _____

Address: _____ Phone: _____-_____-_____

Date of Last Appointment: ___/___/_____ Date of Last X-Ray: ___/___/_____

Why did you leave your previous dentist? _____

Please check (X) if you have or have had problems with any of the following:

□ Yes □ No Bad breath	□ Yes □ No Gums swollen or tender
□ Yes □ No Bleeding gums	□ Yes □ No Jaw pain or tiredness
□ Yes □ No Blisters on the lips or mouth	□ Yes □ No Lip or cheek biting
□ Yes □ No Burning sensation on tongue	□ Yes □ No Loose teeth or broken fillings
□ Yes □ No Chew on one side of mouth	□ Yes □ No Mouth breathing
□ Yes □ No Cigarette, pipe, cigar smoking	□ Yes □ No Orthodontic treatment
□ Yes □ No Clicking or popping jaw	□ Yes □ No Pain around ear
□ Yes □ No Dry mouth	□ Yes □ No Periodontal treatment
□ Yes □ No Fingernail biting	□ Yes □ No Sensitivity to cold, heat, or sweets
□ Yes □ No Food collection between teeth	□ Yes □ No Sensitivity when biting
□ Yes □ No Grinding teeth	□ Yes □ No Sores or growths in mouth

How often do you brush? _____ How often do you floss? _____

How often do you have your teeth cleaned? _____

Do you eat snacks or drink beverages containing sugar between meals 4 or more times per day?

□ Yes □ No