The Art of Dentistry

Dental History Form

Last Dental Visit: Dr. _____ Date: _____

Do you grind your teeth while sleeping? ☐

Are you aware of any bad taste or breath? ☐

On the scale of 1 to 5, how would you rate your mouth? Health: 1 Appearance: 1

What concerns do you have about your mouth?

I, the undersigned, acknowledge that all of the medical and dental information provided is true, and that I have not knowingly omitted any information. I also consent to my physician being contacted, if necessary, for information that may be required for treatment.

Patient or Guardian Signature _____ Date: _____

Printed Name _____

Date	Same Change	Patient Signature	Dr. Initials