# Dresen Restorative Dentistry
# Dental History

Name: _____ Date: _____

Referring Dentist: _____

What is the reason for your visit? _____

_____

Are you presently in any pain? ☐ Yes ☐No For how long? _____
Hot/Cold ☐ Yes ☐No Biting/Pressure ☐ Yes ☐No Swelling ☐ Yes ☐No

Are you wearing anything removable to replace missing teeth? ☐ Yes ☐No
How old are they? _____ Are They Comfortable? ☐ Yes ☐No

Are you satisfied with:
The appearance of your teeth? ☐ Yes ☐No
Your ability to chew & eat? ☐ Yes ☐No

What would you like to change about your mouth, teeth or smile? _____

_____

When was your last dental appointment? _____
What was done? _____

Have you or are you having any head or neck pain? ☐ Yes ☐No
Do you have frequent headaches? ☐ Yes ☐No
Have you ever noticed any popping or clicking of your jaw joint? ☐ Yes ☐No
Are you aware if you clench or grind your teeth? ☐ Yes ☐No

Do you have any sores or lumps in your mouth? ☐ Yes ☐No

Are you comfortable with dental treatment? ☐ Yes ☐No
Would you prefer to use Nitrous Oxide gas during treatment? ☐ Yes ☐No

Is there anything more you would like us to know? _____

_____

_____

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