Grove
Health Dental

Dental History for: (First Name) _____ (Last Name) _____

What made you decide to make this appointment with us today? _____

When did you last visit a dentist? _____ What was done? _____

How often did you visit a dentist before then? _____

What types of dental treatment have you had done in the past? _____

_____

Are your teeth sensitive to: □ Heat □ Cold □ Sweets □ Pressure

Have you had teeth straightened or braces? □ Yes □ No If yes, when?_____

If you could change anything about your smile, what would it be? _____

_____

What do you like the most about your teeth? _____

Do you have, or have you been told, you have TMJ issues? □ Yes □ No
If yes, what treatment was done, if any? _____

Do you hear popping, clicking, or snapping noises when you chew or open your mouth wide? □ Yes □ No

Do you clench or grind your teeth? □ Yes □ No If yes, when? _____

Are you aware of any swelling, lumps or bumps in you mouth/neck/face area? □ Yes □ No

Do you:

□ Eat between meals

□ Drink beverages with sugar

□ Notice unpleasant tastes in your mouth

□ Eat candy, desserts, or sweets

□ Have bad breath

□ Have a dry mouth sometimes

□ Have difficulty swallowing

Is there anything else you would like to share with us about your dental health? _____

_____