Patient Name_____ DOB_____

Dental Health History

Previous Dentist/Practice Name_____ Phone_____

Date of last dental visit_____ Date of last x-rays _____

If you could change one thing about your smile, what would it be?

☐ Spacing (less/more)
☐ Straighten
☐ Whiten
☐ Replace missing teeth
☐ Create symmetry
☐ Address discomfort

Please check anything you have noticed:

☐ Bad breath or taste
☐ Bleeding gums
☐ Change in color of teeth/gums
☐ Cracked or lost fillings
☐ Difficulty opening wide
☐ Dry mouth
☐ Grinding/clenching
☐ Gum disease or Pyorrhea
☐ Jaw clicks/TMJ
☐ Pain in jaw or teeth
☐ Spaces developing
☐ Swelling or lump in mouth
☐ Teeth sensitive to hot, cold or sweets
☐ Teeth tender when chewing
☐ Toothache
☐ Ulcers

How often do you: Brush_____time(s)/day Floss _____time(s)/day Mouthwash _____time(s)/day

Have you been treated for periodontal disease? ☐ Yes ☐ No If yes, when?_____

Have you had orthodontic treatment? ☐ Yes ☐ No If yes, when?_____

If yes, what type of treatment?_____

Do you wear partials or dentures? ☐ Yes ☐ No If yes, do you have discomfort? ☐ Yes ☐ No

Do you have your wisdom teeth? ☐ Yes ☐ No If yes, do you have discomfort? ☐ Yes ☐ No

Please add any comments that are important for the doctor to know_____

_____

_____

_____

To the best of my knowledge, all of these answers and information provided are true and correct. I will not hold Icon Dentistry PA or its personnel responsible for any complication(s) arising from errors or omissions in this form. If I ever have any changes in my health, I am responsible for informing the doctor and staff at the next appointment.

_____ _____

Signature (patient, parent or guardian) Date

_____

Print name