KOHLMEIER DENTAL LLC

DENTAL HISTORY

Patient Name: _____

DOB: _____

General Information

Who was your previous Dentist and how long were you a patient there?	
Date of your last dental exam:	
Date of your last cleaning:	
Do you have any immediate concerns you'd like us to address?	

Personal History

Are you concerned about the appearance of your teeth?	
Have you had any cavities within the past 2 years?	
Are any teeth currently sensitive to biting, sweets, hot, or cold?	
Do you avoid or have difficulty chewing or biting heavily with any hard foods?	
Do you have any problems sleeping, wake up with a headache or with sore or sensitive teeth?	
Do you clench your teeth in the daytime?	
Do you wear, or have you ever worn a bite appliance? Either for clenching at night (a night guard) or for sleep apnea?	
Does the amount of saliva in your mouth seem too little or do you find yourself with a dry mouth often?	

Dental Structural History

Do your gums bleed when brushing or flossing?	
Is brushing or flossing typically painful?	
Have you ever experienced or been told you have gum recession?	
Have you ever been treated for or been told you have gum disease?	
Have you had any teeth removed for braces or otherwise?	
Have you ever had orthodontic treatment like braces or Invisalign?	

KOHLMEIER DENTAL LLC

Are your teeth becoming more crowded, overlapped, or “crooked?”	
Do you frequently get food caught between any teeth?	
Have you noticed your teeth becoming shorter, thinner, or flatter over the years?	
Do you have problems with your jaw joint? (TMD, popping, clicking, deviating from side to side when opening or closing?	

Signature: _____ **Date:** _____