HEIM & CARROLL DMD LLC

DENTAL HISTORY QUESTIONNAIRE

Last Name:____________________ First Name:_________________ Date of Birth______________

1. Do you have a specific dental problem at present?____
2. How did you hear about us?____
3. When was your last dental visit and what was done?____
4. Who was your last dentist?_______________________________ Town_______________ State____
5. Have you ever had:

   a) Full mouth or panoramic x-rays   Yes   No   When___________
   b) Root canal treatment   Yes   No   When___________
   c) Orthodontic treatment (braces)   Yes   No   When___________
   d) Periodontic Treatment (gumwork)   Yes   No   When___________
   e) Any injuries to your teeth   Yes   No   When___________
   f) Wisdom teeth removed   Yes   No   How many______
   g) Implants   Yes   No   When ___________

6. Do you have any fears or anxieties about dental treatment___________________________________
7. How often do you brush?___________________ Floss?_____________________
8. What kind of toothbrush do you use? (electric, manual)____
9. Do you use anything else to clean your teeth? (toothpick, rubber tip, stimudent) __________________
10. Is there something you would like to change about your smile?_________________________________
11. Do you have any concerns about bad breath? ____
12. Do you clench your teeth? ____
13. Do you wear an oral appliance? (mouth guard, retainer)____