

HANSEN & ASSOCIATES
6659 KIMBALL DRIVE NW, SUITE D401, GIG HARBOR, WA 98335

NAME: _____ DATE: _____ REVIEWED BY: _____

DENTAL HISTORY:

Approximate date of last dental visit: _____ When were your teeth last cleaned professionally? _____
Have you been satisfied with your past dentistry? Yes/No Explain: _____
Has fear of discomfort prevented you from regular dental visits? Yes/No Explain: _____
Have you ever had an unpleasant dental experience? Yes/No Explain: _____
Have you ever used sedation for dentistry? Yes/No If yes, when? _____

Have you ever had periodontal treatment? Yes/No If yes, when? _____
Have you ever had orthodontic treatment? Yes/No If yes, when? _____
Have you ever had oral surgery? Yes/No If yes, when? _____

Each day how many times do you brush? _____ Floss? _____ What type of toothbrush do you use? Manual (or) Electric
Do your gums bleed easily? Yes/No Do your gums feel tender or irritated? Yes/No If yes, when? _____
Do you avoid areas of your mouth while brushing? Yes/No If yes, why? _____
Do you catch food between your teeth? Yes / No If yes, where? _____
Do you have concerns about bad breath? Yes / No
Do you chew on both sides of your mouth? Yes/No If no, why? _____
Are your teeth sensitive to any of the following: Hot Cold Sweets Chewing Bite Other: _____

Do you frequently chew gum? Yes/No
Do you often have headaches? Yes/No If yes, when? _____
Does your jaw ever feel tired? Yes/No If yes, when? _____
Are you aware of clenching or grinding your teeth? Yes/No If yes, when? _____
Have you ever worn a bite guard? Yes/No If yes, when? _____

Do you have pain in your ears? Yes/No
Do you have pain in your neck, shoulders or back? Yes/No
Do you hear any clicking or popping noises from your jaw? Yes/No If Yes, when did you first notice it? _____
Do you experience any pain in your jaw joint? Yes/No If yes, when? _____
Have you ever had an injury or trauma to your head or neck? Yes/No Explain: _____

Do you smoke or use tobacco products? Yes/No If yes, what type? _____ How often? _____
Have you ever felt self-conscious about the appearance of your teeth? Yes/No
Have you done any tooth whitening? Yes / No If no, are you interested in learning about tooth whitening? Yes / No
Are you interested in learning about ways to improve your smile? Yes / No
Is it important to you to retain your natural teeth? Yes/No

On a scale of 1-10, where would you rate your stress level? _____

ADDITIONAL COMMENTS:

FOR OFFICE USE:

CC: _____

_____ REVIEWED BY: _____