Robb HeinricH DDS
Restorative &
Aesthetic Dentistry

Dental History

Date of last dental exam/cleaning and x-rays _____

Name of previous dentist _____

Reason for leaving _____

Check yes or no if you have had any of the symptoms listed below

Y N

❑ ❑ Are you having any discomfort at this time? _____

❑ ❑ Sensitive teeth _____

❑ ❑ Bleeding gums _____

❑ ❑ Clicking or popping jaw, pain, TMJ, TMD _____

❑ ❑ Dry mouth _____

❑ ❑ Do you clench or grind your teeth _____

❑ ❑ Have you ever had any serious or difficult problems associated with any previous dental treatment?

If yes, please explain_____

❑ Other_____

How many times each day do you brush your teeth?____ How many times each week do you floss? ____

Do you use an electric tooth brush?_____ If yes, which one?_____

Periodontal History

Y N Don't Know

❑ ❑ ❑ Have you ever been told you have periodontal disease?

❑ ❑ ❑ Has anyone in your family had/have periodontal disease?

❑ ❑ ❑ Have you ever had periodontal surgery?

How would you rate your dental health on a scale of 1 (poor) to 10 (excellent) _____

How would you rate your overall health on a scale 1 (poor) to 10 (excellent) _____

Are you happy with the appearance of your smile? Y N Would you like whiter teeth? Y N

Have you whitened your teeth previously? Y N Are you interested in discussing cosmetic dentistry with us? Y N

What is most important to you about your dentist?_____

_____

What is most important to you about your dental office/team?_____

_____

Is there anything else you would like us to know about your previous dental experiences?_____

_____

_____

Is there anything we can do to make your dental visits easier for you?_____

_____

Do you struggle to have a good night sleep, or know you have Sleep Apnea?

_____