Initial Visit – Dental History

Name: ______________________________

1. Reason for today's visit:____
2. Are you currently in any pain?____

	YES	NO
3. Do your gums ever bleed?	YES	NO
4. Have you ever been diagnosed with periodontal (gum) disease?	YES	NO
5. Do you experience any sensitivity with your teeth?	YES	NO
6. Are you aware of grinding or clenching your teeth?	YES	NO
7. Do you now have or have you ever experienced pain in your jaw joint?	YES	NO
8. Would you like whiter teeth?	YES	NO
9. Are you happy w/ how your smile looks?	YES	NO

If not, what would you change?____

10. Have you had previous orthodontic treatment?	YES	NO
11. Would you be interested in Invisalign treatment (clear retainer orthodontic movement) to straighten your teeth?	YES	NO

➢ Please provide information of you previous dentist:
  Name: ____
  Address: ____
    Date of Last Exam:_________________________
    Date of Last Dental X-rays:___________________

➢ How did you hear about us?____