

## Dental History

What is your primary reason for seeking dental care today? (Ex: check-up, pain, dental concerns, other)

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What is the month/year of your last dental visit? \_\_\_\_\_

How often do you visit the dentist? \_\_\_\_\_

Yes  No Are your teeth sensitive to hot/cold/pressure/sweets?

Yes  No Do your gums feel tender and/or bleed?

Yes  No Have you had periodontal (gum) treatment?

Yes  No Do you have a dry mouth?

Yes  No Do you experience acid reflux, especially at night?

Yes  No Do you have bad breath or a bad taste in your mouth?

Yes  No Does food catch between your teeth?

Yes  No Do you have problems with teeth/fillings breaking?

Yes  No Do you clench or grind your teeth?

Yes  No Do you have tired jaws especially in the morning?

Yes  No Are you unhappy with the appearance of your teeth?

Yes  No Are you interested in whitening your teeth?

Yes  No Are you interested in replacing any missing teeth?

How often do you brush your teeth? \_\_\_\_\_

How often do you floss your teeth? \_\_\_\_\_

What types of beverages do you typically drink between meals? \_\_\_\_\_

## HIPAA Acknowledgment

I acknowledge that I have received or read a copy of the Notice of Privacy Practices (HIPAA form). You may either request a copy or see the form in the reception area and on our website at [www.rileydentalgroupky.com](http://www.rileydentalgroupky.com).

Signature of Patient, Parent, or Guardian \_\_\_\_\_ Date \_\_\_\_\_