SMILES IN THE VALLEY
FAMILY DENTISTRY

320 N. Maple Street
Orwell, Ohio 44076
Phone: (440) 437-8444
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New Patient Dental History

Previous General Dentist _____ Date of last visit_____

What concerns you most about your teeth?

_____

YES NO Are you presently in any dental pain?

YES NO Have you ever experienced any unfavorable reaction to dentistry?

YES NO Have there been any injuries to face, mouth, or teeth?

YES NO Is any part of your mouth sensitive to temperature? Where? _____

YES NO Is any part of your mouth sensitive to pressure? Where? _____

YES NO Do your gums bleed when you brush?

YES NO Are you a mouth breather?

YES NO Have you ever seen an orthodontist? If yes, who and when?_____
_____

YES NO Do your teeth/jaws ever feel uncomfortable when you awake in the morning?

YES NO Are you aware of your jaw clicking or popping?

YES NO Are you aware of clenching your teeth during the day?

YES NO Have you ever been told that you grind your teeth?

YES NO Do you have “tension” headaches?

YES NO Do you floss your teeth? If so, how often? _____