Monica M Pierpan, DDS, PA
Henry J. Pierpan, DDS, PA

Name:
Date:
BP:

DENTAL HEALTH HISTORY

How did you hear about our practice?

When was your last dental visit?
And what was that visit for?

Are you having any dental problems that require immediate attention?

Do you smoke or use tobacco products?
What age did you start?

Do any of the following cause tooth discomfort or pain? If so, note which area of your mouth.
Hot-
Cold-
Sweets-
Chewing-

How often do you brush your teeth?
Floss?
Waterpick?

Do your gums bleed or feel tender or swollen?
Have you had any periodontal treatment (treatment for gum disease)?

Do you clench or grind your teeth?
Do your jaws ever feel tired or ache?
Click or Pop?
Headaches?

Have you ever had orthodontic treatment (braces)?
When?
Where?

How do you feel about the appearance of your smile?

Have you ever had any unpleasant dental experiences?

_____ _____
(Patient Signature) (Date)