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Welcome to the Practice of
PAUL J. KRAMER, D.M.D. & JAMES K. KRAMER, D.M.D., P.A.

Dental History Form

Name of patient: * ______________________

1. What is the reason for your visit today? ______________________

2. When was the last time you saw a Dentist? What was done at that time? ______________________

3. Have you enter been treated for periodontal disease (gum disease)? ◯ Yes ◯ No

4. Have you had orthodontic treatment (braces)? ◯ Yes ◯ No

5. Do you snore? ◯ Yes ◯ No

6. Does Dental treatment make you nervous? ◯ Yes ◯ No

7. Have you ever had an unpleasant dental experience? ______________________

8. Do you experience any of the following?

- ☐ Bleeding or sore gums
- ☐ Bad breath/unpleasant taste
- ☐ Frequent dry mouth
- ☐ Tingling or burning toungue or lips
- ☐ Swelling or lumps in mouth
- ☐ Sores in mouth
- ☐ Food trapping between teeth
- ☐ Loose teeth
- ☐ Sensitive to hot
- ☐ Sensitive to cold
- ☐ Sensitive to sweets
- ☐ Clicking/popping jaw
- ☐ Frequent headaches
- ☐ Grinding/clenching

9. How often do you brush your teeth and do you use dental floss? ______________________

10. What type of toothbrush do you use

☐ Soft ☐ Medium ☐ Hard ☐ Electric

Smile Evaluation

What other cleaning aids, devices, or rinses do you use? ______________________

1. Are you self conscious when you smile in front of other people or pictures? ◯ Yes ◯ No

2. Do you ever cover your smile with your hand? ◯ Yes ◯ No

3. Do you wish your teeth were whiter? ◯ Yes ◯ No

4. Do you dislike the shape of your teeth? ◯ Yes ◯ No

5. Do you have spaces between your teeth that you don't like? ◯ Yes ◯ No

6. Do you have old fillings or dental work that you don't like looking at? ◯ Yes ◯ No

7. If you could wave a "magic wand" and change the appearance of your smile, how would you like to look? ______________________

Please list any questions and concerns that you may have about your mouth or oral health:

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Signature ____ **Date** ____________

Response Date: ____________