WELLESLEY DENTAL GROUP
DRS. ALI & ALI

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Dental History

Patient Name_____ Date of Birth_____

Do you have any current dental problems? ☐ Yes ☐ No

If yes, explain_____

Are you being treated by a dentist now? ☐ Yes ☐ No

If yes, who?_____

When was your last full mouth x-ray series taken?_____

When was your last cleaning?_____

Do you wear dentures? Yes ☐ No ☐ If so, How old are your current dentures?_____

Do you currently wear a biteguard/nightguard? ☐ Yes ☐ No

Do dental procedures make you nervous? ☐ Yes ☐ No

Have you ever had Intravenous (IV) Sedation? ☐ Yes ☐ No

Have you ever had Nitrous Oxide (gas)? ☐ Yes ☐ No

Do your gums bleed easily? ☐ Yes ☐ No

Do you have sensitive teeth? ☐ Yes ☐ No

Are your gums swollen? ☐ Yes ☐ No

Do you have any loose teeth? ☐ Yes ☐ No

Have you had braces (orthodontics)? ☐ Yes ☐ No

Do you like the appearance of your teeth? ☐ Yes ☐ No

Are your teeth as straight as you would like? ☐ Yes ☐ No

Do you have spaces that you do not like? ☐ Yes ☐ No

Do you like the color of your teeth? ☐ Yes ☐ No

Do you like the shape of your teeth? ☐ Yes ☐ No

Are there old fillings or dental work you don't like? ☐ Yes ☐ No

Do you like the way your bite looks and feels? ☐ Yes ☐ No

Do you have any of the following? (Check all that apply)

☐ Jaw Pain ☐ Irregular bite ☐ Shifting Jaw ☐ Aching Neck

Are your teeth: ☐ Chipped ☐ Too Long ☐ Too Short

Thank you!