WESTERN IOWA
PERIODONTICS &
IMPLANT DENTISTRY

Dental History

Reason for visit: _____
Date of last dental visit:_____
Date of last dental x-rays:_____
How often do you floss? _____ Brush?_____

No	**?**	**Yes**	Bad Breath
No	**?**	**Yes**	Bleeding, Red, Swollen Gums
No	**?**	**Yes**	Broken/Loose teeth or fillings
No	**?**	**Yes**	Clicking or popping jaw
No	**?**	**Yes**	Grinding teeth
No	**?**	**Yes**	Pain around ear/side of face
No	**?**	**Yes**	Sores/Blisters in mouth

List any other dental concerns/pain:_____
_____

Signature:_____ Date:_____