

ANETT JOHN DDS, LLC

Cosmetic and Family Dentistry of Chevy Chase

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DENTAL HISTORY FORM

PATIENT NAME: _____ DATE: _____

Please describe the primary reason for your visit (concern)

- _____
- _____
- _____

How long has this been going on and what would you like done?

If you could rate your smile from 1-10, what would it be? _____

Would you like to improve your smile? Y N How? _____

Have you ever suffered from, or been told you may have any of the following?

- | | | | | | |
|------------------------|---|---|----------------------------------|---|---|
| 1. Gum Disease | Y | N | 5. Sleep: Snoring/Stop Breathing | Y | N |
| 2. Bruxism or Grinding | Y | N | 6. Bad Breath | Y | N |
| 3. Jaw pain or TMJ | Y | N | 7. Headaches or Migraines | Y | N |
| 4. Dental Pain | Y | N | 8. Tooth Sensitivity to Hot/Cold | Y | N |
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DOCTOR'S NOTES:

