Chelsea Baraff, DMD
1470 SW Knoll Ave Ste 101
Bend, OR 97702

Dental History

Today's Date: _____________ Patient Name: ____________________________________

Are you currently experiencing any dental pain/discomfort? Yes / No
If yes, please explain: ____

Do you have any particular dental concerns/desires at this time? Yes / No
If yes, please explain: ____

Approximate date of your last dental appointment and reason: __________________________

Have you had any problems associated with previous dental treatment? Yes / No
If yes, please explain: ____

Do your gums bleed when you brush or floss? Yes / No
Are your teeth sensitive to hot/cold, sweets or pressure? Yes / No
Is your mouth dry? Yes / No
Have you had any periodontal (gum) treatments or "deep cleanings"? Yes / No
Have you ever had orthodontic treatment (braces)? Yes / No
Do you have earaches or neck pains? Yes / No
Do you have any clicking/popping or discomfort of the jaw? Yes / No
Do you grind your teeth? Yes / No
Have you ever worn or been advised a nightguard? Yes / No
Do you have or get sores/ulcers in your mouth? Yes / No
Do you wear dentures/partials? Yes / No
Have you ever had any serious injury to your head/mouth? Yes / No ____________________
How do you feel about your smile? ____