German Village
Dental Group

Nicole K. Munz, DDS - General Dentist

DENTAL HISTORY

PATIENT NAME _____ **BIRTH DATE** _____

Are you currently experiencing any dental discomfort? ☐ YES ☐ NO

If YES, please explain _____

Previous Dentist's Name _____

Date of last dental cleaning _____

Please check YES or NO if you have had problems with any of the following and location when indicated:

Bad Breath	☐ YES	☐ NO				
Clicking or popping jaw	☐ YES	☐ NO				
Previous orthodontic treatment	☐ YES	☐ NO				
Grinding or clenching	☐ YES	☐ NO				
Bleeding during brushing/flossing	☐ YES	☐ NO				
Periodontal treatment	☐ YES	☐ NO				
Wears partials or dentures	☐ YES	☐ NO	☐ TOP	☐ BOTTOM		
Sensitivity to cold	☐ YES	☐ NO	☐ TOP	☐ BOTTOM	☐ LEFT	☐ RIGHT
Sensitivity to hot	☐ YES	☐ NO	☐ TOP	☐ BOTTOM	☐ LEFT	☐ RIGHT
Sensitivity when biting	☐ YES	☐ NO	☐ TOP	☐ BOTTOM	☐ LEFT	☐ RIGHT
Sensitivity to sweets	☐ YES	☐ NO	☐ TOP	☐ BOTTOM	☐ LEFT	☐ RIGHT
Loose teeth or broken fillings	☐ YES	☐ NO	☐ TOP	☐ BOTTOM	☐ LEFT	☐ RIGHT
Sores or lumps in mouth	☐ YES	☐ NO	☐ TOP	☐ BOTTOM	☐ LEFT	☐ RIGHT

Is there anything you would like to change to enhance your smile? ☐ YES ☐ NO

If YES, please explain

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN _____ DATE _____

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