

**GARTNER ORTHODONTICS, LTD.
ADULT DENTAL HISTORY**

Patient's Name _____

1. Purpose of this visit: _____

2. Are you aware of a problem? _____

3. Dentist's name: _____
Address: _____
4. How long since your last dental visit? _____
5. Were dental x-rays taken? _____

(Circle the appropriate answers)

- | | | | |
|-----|---|-----|----|
| 6. | Do you clench or grind your teeth? | Yes | No |
| 7. | Does your jaw click or pop? | Yes | No |
| 8. | Have you experienced pain or soreness in the muscles or around your ears? | Yes | No |
| 9. | Do you have frequent headaches, neckaches or shoulder aches? | Yes | No |
| 10. | How often do you brush your teeth? _____ | | |
| 11. | Do you use dental floss? | Yes | No |
| 12. | Have you ever had gum treatment or surgery? | Yes | No |
| 13. | Are you happy with the appearance of your teeth? | Yes | No |

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S SIGNATURE _____ DATE _____