RINALDI
DENTAL ARTS
SMILE BEAUTIFICATION // ORAL RESTORATION // WHOLE BODY WELLNESS

5481 Wisconsin Ave, Suite 221
Chevy Chase, MD 20815
301-652-3355

Personal Dental History

NAME: _____ **DATE:** _____

What name would you like us to call you? _____

Purpose of today's visit:

_____

_____

_____

Why have you decided to deal with this now?

_____

Have you consulted with any other dentist about this? ☐ Yes ☐ No **If yes, what was discussed or done?**

_____

_____

When was your last dental & cleaning check up? _____

Previous dentist? _____

Do you now have or have you ever had any of the following:

Have gum disease (gingivitis)	☐ Yes	☐ No	Bad Breath	☐ Yes	☐ No
Grind your teeth	☐ Yes	☐ No	Sensitivity to: Cold	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No	Heat	☐ Yes	☐ No
			Sweets	☐ Yes	☐ No
Jaw Pain or tiredness	☐ Yes	☐ No	Biting/Chewing	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No	Wake up tired	☐ Yes	☐ No
Lip or cheek biting	☐ Yes	☐ No	Have you ever been told you snore	☐ Yes	☐ No
Loose or broken teeth or fillings	☐ Yes	☐ No	Sores, blisters or growths	☐ Yes	☐ No
Food collection between teeth	☐ Yes	☐ No	Missing teeth	☐ Yes	☐ No
Have you ever had orthodontics?	☐ Yes	☐ No	Have you been treated for Periodontal disease?	☐ Yes	☐ No

Would you like to know what options are available to you to:

1. Create a more Attractive Smile	☐ Yes	☐ No	3. Keep your Teeth for Life	☐ Yes	☐ No
2. Look Younger	☐ Yes	☐ No	4. Sleep Better	☐ Yes	☐ No

What would you like to see done now?

_____

_____