DENTAL HISTORY

Patient Name

Welcome! So that we may provide you with the best possible care please complete both the medical and dental history forms All information is completely confidential

What is the reason for your visit today? ______________________

Date of Last Dental visit__________ **Last Dental Cleaning**__________ **Last Full Mouth X-rays**__________

What was done at your last dental visit? ______________________

Previous Dentist's Name ______________________

Address ______________________ State_____ Zip_______ Phone_______

How often do you have dental exams? ______________________

How often do you brush your teeth __________ How often do you floss? __________

What other dental aids do you use? (Electric toothbrush, toothpick, etc.) __________

Do you have any dental problems now? Yes No

If yes, please describe: ______________________

Are any of your teeth sensitive to:

Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or chewing?	Yes	No
Bad breath or foul taste?	Yes	No
Do you frequently get cold sores, blisters or other oral lesions?	Yes	No

Do your gums bleed or hurt?	Yes	No
Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught between your teeth?	Yes	No

If yes, where? __________

Do you:

Clench or grind your teeth during the day or at night?	Yes	No
Bite your lip or cheeks regularly?	Yes	No
Hold foreign objects with your teeth? (Pencils, fingernails, pins, etc.)	Yes	No
Mouth breath during the day or night	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Smoke/chew tobacco	Yes	No

Have you ever had:

Orthodontic Treatment?	Yes	No
Oral Surgery?	Yes	No
Periodontal Treatment?	Yes	No
Your teeth ground or bite adjusted?	Yes	No
A bite plate or mouthguard?	Yes	No
A serious injury to the mouth or head?	Yes	No

If so, please describe __________

Have you experienced:

Clicking or popping of the jaws?	Yes	No
Pain of the joint, ear, side of the face?	Yes	No
Difficulty opening or closing?	Yes	No
Headaches, neck aches, or shoulder aches?	Yes	No

Are you satisfied with the way your teeth look and feel?	Yes	No
Do you wish to keep all of your teeth for the rest of your life?	Yes	No
Do you feel nervous about having dental treatment?	Yes	No

If so, what is your biggest concern? __________

Have you ever had ah upsetting dental visit? Yes No

If so, please describe __________

Is there anything else about having dental treatment that you would likes us to know? Yes No

If yes, please describe ______________________

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