DENTAL HISTORY
Patient Name: _____

Welcome! So, that we may provide you with the best possible care please complete this dental history form. 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-ray** _____
What was done at your last dental visit? _____
Previous Dentist's Name _____ Telephone _____
Address _____ State _____ Zip _____

How often do you have dental examinations? _____
How often do you brush your teeth? _____ How often do you floss? _____
Do you use an electric toothbrush? Yes No
Have you ever used or are currently using topical fluoride? Yes No
What other dental aids do you use? (Interplak, 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
Have you noticed any mouth odors or bad tastes? ……Yes No
Do you frequently get cold sores, blisters or any 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 in between your teeth? ……Yes No
If yes, where _____

Do you:
Clench or grind your teeth while awake or asleep? ……Yes No
Bite your lips or cheeks regularly? ……Yes No
Hold foreign objects with your teeth? (pencils, pipe, etc.) ……Yes No
Mouth breathe while awake or asleep? ……Yes No
Have tired jaws, especially in the morning? ……Yes No
Snore or have any other sleeping disorders? ……Yes No
Smoke/chew tobacco or use other tobacco products? ……Yes No

DENTAL HISTORY

Patient Name: _____

Have you ever had:

Orthodontic treatment? ……Yes No
Oral Surgery? ……Yes No
Periodontal treatment? ……Yes No
Your teeth ground or the bite adjusted? ……Yes No
A bite plate or mouth guard? ……Yes No
A serious injury to the moth or head? ……Yes No
Please describe, including cause _____

Have you experienced:

Clicking or popping of the jaw? ……Yes No
Pain? (joint, ear, side of face)? ……Yes No
Difficulty in opening or closing the mouth? ……Yes No
Difficulty in chewing on either side of the mouth? ……Yes No
Headaches, neckaches or shoulder aches? ……Yes No
Sore muscles (neck, shoulders)? ……Yes No

Are you satisfied with your teeth's appearance? ……Yes No
Would you like to replace your silver fillings? ……Yes No
Would you like to keep all of your teeth all of your life? ……Yes No

Do you feel nervous about having dental treatment? ……Yes No
If yes, please describe _____

Have you ever had an upsetting dental experience? ……Yes No
If yes, please describe _____

Have you ever been told to take a pre-medication prior to dental treatment? ……Yes No

Is there anything else about having dental treatment that you would like us to know? ……Yes No
If yes, please describe

_____
_____
_____