

DENTAL HISTORY

Patient Name _____

*Welcome! So that we may provide you with the best possible care **PLEASE COMPLETE BOTH SIDES** of this medical/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-rays:** ____ / ____ / ____
What was done at your last dental visit? _____

Previous Dentist's Name _____
Address _____ State _____ Zip _____
Telephone _____

How often do you have dental examinations? _____
How often do you brush your teeth? _____ How often do you floss? _____
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 taste? yes no
- Do you frequently get cold sores, blisters or any other oral lesions? yes no

Do your gums bleed or hurt?

- 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, fingernails or cheeks regularly? yes no
- Hold foreign objects with your teeth? (pencils, pipe, pins, nails) yes no
- Mouth breathing while awake or asleep? 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 the bite adjusted? yes no
 - A bite plate or mouth guard? yes no
 - A serious injury to the mouth or head? yes no
- If yes, 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
- Do you feel nervous about having dental treatment? yes no
- If so, what is your biggest concern? _____
- Have you ever had an upsetting dental experience? yes no
- If yes, please describe _____

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