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?____

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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____ 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? (water pik, toothpick, etc.) ____

Do you have any dental problems now? Yes No

If yes, please describe: ____

Are any of your teeth sensitive to:	Yes	No
Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?		
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
	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
	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Smoke/chew tobacco?		

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?		
If so, please describe, including cause ________________________________		
Have you experienced:	Yes	No
Clicking or popping of the jaw?	Yes	No
Pain?(joint, ear, side of face)	Yes	No
Difficulty in opening or closing the mouth?		
Difficulty in chewing on either side of the mouth?	Yes	No
	Yes	No
Headaches, neck aches or shoulder aches?	Yes	No
Sore muscles(neck, shoulders)?		
Are you satisfied with your teeth's appearance?	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 so, what is your biggest concern? ________________________________		
Have you ever had an upsetting dental experience?	Yes	No
If so, please describe_______________ ________________________________		

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

If yes, please describe____

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had.

Yes No