PATIENT NAME:

DENTAL HISTORY

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 _____

Telephone _____

How often do you have dental examinations? _____

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

Have you ever used topical fluoride? Yes ☐ No ☐

What other dental aids do you use? (electric toothbrush, water flosser, 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?	☐	☐
Sweets?	☐	☐
Biting or chewing?	☐	☐
Have you noticed any mouth odors or bad tastes?	☐	☐
Do you frequently get cold sores, blisters or any other oral lesions?	☐	☐
Do your gums bleed or hurt?	☐	☐
Have your parents experienced gum disease or tooth loss?	☐	☐
Have you noticed any loose teeth or change in your bite?	☐	☐
Does food tend to get caught in between your teeth?	☐	☐

If yes, where? _____

Have you ever had:	Yes	No
Orthodontic treatment?	☐	☐
Oral Surgery?	☐	☐
Periodontal treatment?	☐	☐
Your teeth ground or the bite adjusted?	☐	☐
A bite plate or mouth guard?	☐	☐
A serious injury to the mouth or head?	☐	☐

If so, please describe, including the cause _____

_____

Have you experienced:		
Clicking or popping of the jaw?	☐	☐
Pain? (joint, ear, side of face)	☐	☐
Difficulty in opening or closing the mouth?	☐	☐
Headaches, neck aches or shoulder aches?	☐	☐
Sore muscles (neck, shoulders)?	☐	☐

Do you:		
Clench or grind your teeth while awake or asleep?	☐	☐
Bite your lips or cheeks regularly?	☐	☐
Hold foreign objects with your teeth? (pencils, pipe, pins, fingernails)	☐	☐
Mouth breathe while awake or asleep?	☐	☐
Have tired jaws, especially in the morning?	☐	☐
Snore or have other sleeping disorders?	☐	☐
Smoke/chew tobacco or use other tobacco products?	☐	☐

Are you satisfied with your teeth's appearance?		
Would you like to keep all of your teeth all of your life?	☐	☐
Do you feel nervous about having dental treatment?	☐	☐
Have you ever had an upsetting dental experience?	☐	☐

If so, what is your biggest concern? _____

_____

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 _____

_____