

Patient Name _____
Patient Account No. _____

DENTAL HISTORY

Medical Alert _____

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 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, 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? | 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 so, 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?

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 yes, please describe _____

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

If yes, please describe _____

(Please complete other side)