DENTAL HISTORY

Patient Name	Date of Birth: Age:
Patient Account Number (office use only)	Medical Alert (office use only)

Welcome! So that we may provide you with the best possible care,
please complete this dental history form.
All information is completely confidential.

1. What is the reason for your visit today? ______________________________
2. Date of Last Dental Visit ______________ Last Dental Cleaning ______________ Last Full Mouth X-rays ______________
3. What was done at your last Dental Visit? ______________________________
4. Previous Dentist's Name______________________ Telephone ______________
   Address ______________________________ State ______________ Zip ______________
5. How often do you have a dental examination? ______________________________
6. How often do you brush you teeth? ______________ How often do you floss? ______________
7. What dental aids do you use? (electric toothbrush, toothpick, etc.) ______________________________
8. 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
Snore or have any other sleep disorder? ………………. Yes No
Smoke/chew tobacco or use other tobacco products? …...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
Headaches, neck aches or shoulder aches? ……..……… Yes No
Sore muscles (neck, shoulders)? ……………………….... Yes No

Are you satisfied with our teeth's appearance?

Would you like to keep all of your teeth all of your life? ………………………………………………….. Yes No
Do you feel nervous about dental treatment? …………... Yes No
If yes, what is your biggest concern?
____
Have you ever had an upsetting dental experience? ……. Yes No
If yes, please describe______________________________
____

9. 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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