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Liberty Dental Associates
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LIBERTY DENTAL ASSOCIATES
PATIENT DENTAL HISTORY/QUESTIONNAIRE

Dental Summary:
(Office Use Only)

PERIO: **TYPE:** **SPECIALIST:** **DATES:** **PM:**

START HERE

PLEASE COMPLETE THE FOLOWING FORM (3 PAGES):

PATIENT'S NAME: _____ **DATE:** _____ YES / NO

1. **What is the reason for your visit at this time:** _____
   _____
   _____

2. **Please list the name and address of your previous Dentist (also phone number if known):** _____
   _____

3. **Would you prefer that we *NOT* contact your previous Dentist? This includes prior records and x-rays.** ☐ ☐

4. **When did you last see your previous Dentist/Hygienist, and, what was the reason for that visit?** _____
   _____

5. **When were your last full mouth series of x-rays (12-18 in a set) or Panorex x-ray taken?** _____

6. **Did you have any dental x-rays taken within the last year?** ☐ ☐

7. **How often do you brush your teeth daily?** _____ **How much time each time?** _____

8. **How often do you replace your toothbrush or electric brush head?**
   _____

9. **How often do you floss/tape your teeth daily?** _____

10. **What *brand* and *bristle type* toothbrush do you currently use (example Crest, medium bristles):** _____
    _____

11. **What *brand* and *type* dental floss/tape do you currently use:** _____

12. **What *brand* and *type* toothpaste do you currently use:** _____ ☐ ☐

13. **Do you use a Mouthrinse/mouthwash? If yes what:** _____

14. **Please list any additional dental aids (Water-Pik, Stimudents, etc.) that you are currently utilizing:** _____
    _____

15. **Please list any dental pain, soreness, or discomfort you are now experiencing:** _____
    _____

16. **If the last question was answered, please list when you first noticed this problem:** _____

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YES / NO

17. Do you have any special concerns about your mouth or teeth? ☐ ☐
    If yes, please list/explain: _____
18. Are you nervous about receiving dental treatment? ☐ ☐
19. Have you ever had an unpleasant experience in a dental office? ☐ ☐
    If yes, please list and explain: _____
    _____
20. Have you ever experienced medical complications following or during dental treatment? ☐ ☐
    If yes, please list and explain: _____
    _____
21. Do your gums bleed when you brush and/or floss? ☐ ☐
22. Have you been given instructions in the past on how to effectively brush and floss? ☐ ☐
23. Have you ever had a Registered Dental Hygienist clean your teeth? ☐ ☐
24. Do you realize at this office our Hygienists not only clean the teeth but they do scaling, oral cancer screening, periodontal charting, and x-rays as requested by the Doctor (and permitted by Ohio law)? ☐ ☐
25. Do you have any objections to this policy? ☐ ☐
26. Have you ever been treated for Periodontal Disease; Gum Disease; or Pyorrhea? ☐ ☐
    If yes, please list when and by whom? _____
27. Do you presently have any sores, growths, or infections in your mouth? ☐ ☐
    If yes, how many and where are they located: _____
28. Have you ever received an injury to the head, face, or neck? ☐ ☐
    If yes, please describe: _____
29. Do you currently use, (OR have you used), any tobacco products in any form (smoking, chewing, snuff/dip, etc.)? If yes, please list which one (s)), how much per day, and how long have you participated in this activity: _____ ☐ ☐
30. Do you consume any alcoholic beverages? ☐ ☐
    If yes, please explain what and how much: _____
31. Do you use any recreational drugs such as cocaine, marijuana, etc.? ☐ ☐
    If yes, explain: _____
32. Do you have any oral habits which might affect your dental health? ☐ ☐
    If yes, explain: _____
33. Have you ever worn dental braces or retainers? ☐ ☐
    If yes, please list the Doctor who treated, location, and date (s): _____
    _____
34. Do you object to receiving fluoride treatments for your teeth to help protect them, if the Doctor or the Hygienist feel this necessary. Please note that this may not be covered by insurance. ☐ ☐
35. How would you describe your overall dental health: _____
    _____
    _____
36. Are you aware that we will recommend the best treatment for your health? We do not permit insurance carriers or others to dictate treatment, or change this philosophy. Your health is what is paramount to us - not what your insurance may, or may not cover. ☐ ☐

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Please check (☑) any applicable areas below, which you have had in the past, or now have:

PAIN
- ☐-Pain in Face
- ☐-Pain in Mouth
- ☐-Pain in Ears
- ☐-Pain in Tooth/Teeth
- ☐-Pain in Jaws
- ☐-Throbbing Toothache

DISCOMFORT
- ☐-Dull Toothache
- ☐-Cheek Biting
- ☐-Tooth/Teeth Sensitive to Hot
- ☐-Tooth/Teeth Sensitive to Cold
- ☐-Tooth/Teeth Sensitive to Sweets
- ☐-Tooth/Teeth Sensitive to Air
- ☐-Bleeding Gums
- ☐-Sore Gums
- ☐-Food Collecting Between Teeth
- ☐-Facial Swelling
- ☐-Unpleasant Taste
- ☐-Bad Breath
- ☐-Poor Fitting Denture
- ☐-Lump or Swelling in Mouth
- ☐-Dry Mouth
- ☐-Difficulty Opening Mouth
- ☐-Difficulty Closing Mouth

OCCLUSION
- ☐-Jaw Joint Sounds/Clicking
- ☐-Clenching
- ☐-Grinding of Teeth
- ☐-Problems Chewing/Masticating
- ☐-Poorly Functioning/Fitting Dentures
- ☐-Poorly Functioning/Fitting Partials
- ☐-Poorly Functioning Fillings
- ☐-Poorly Functioning Crowns/Bridges
- ☐-Poorly Functioning Teeth
- ☐-Crooked Teeth

PROBLEMS/CONDITIONS
- ☐-Difficulty Flossing Teeth
- ☐-Difficulty Flossing Between Teeth
- ☐-Difficulty Brushing Teeth
- ☐-Food Wedging Between Teeth
- ☐-Loose Fillings
- ☐-Loose Crown or Bridge
- ☐-Missing Teeth
- ☐-Lost Fillings/Crowns/Bridges
- ☐-Loose Teeth
- ☐-Soft Teeth
- ☐-Chipped Tooth/Teeth
- ☐-Broken Tooth/Teeth
- ☐-Discolored Teeth
- ☐-Decay/Cavities
- ☐-Osteoporosis/Calcium Deficiency
- ☐-Thumb Sucking
- ☐-T.M.J.
- ☐-Frequent Headaches
- ☐-Inflamed Tonsils or Adenoids
- ☐-Mouth Breathing
- ☐-Bruise Easily
- ☐-Mercury Allergy

PAST TREAMENT FOR/INVOLVING
- ☐-Periodontal Disease
- ☐-Root Canal Therapy
- ☐-Extractions at Oral Surgeon
- ☐-Treated As Child at Pediatric Dentist
- ☐-Orthodontics/Braces
- ☐-Oral Cancer
- ☐-Other Cancer
- ☐-Radiation Therapy
- ☐-Chemotherapy
- ☐-Extensive Dental Treatment

PERSONAL
- ☐-I do not like the color of my teeth
- ☐-I do not like the shape of my teeth
- ☐-I do not like the look of my teeth
- ☐-I do not like the color of my fillings
- ☐-I have a fear of needles
- ☐-Anesthesia does not work well on me
- ☐-I have been treated roughly by dentist/ hygienist in past
- ☐-I do not like coming to the dental office
- ☐-I prefer your staff use my last name
- ☐-Other (Please list/explain/describe):

All Patients Please Read This Next Section—Then Sign And Date

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED ALL QUESTIONS, AND ADDRESSED ALL STATEMENTS ON ALL THREE PAGES OF THIS MEDICAL HISTORY/QUESTIONNAIRE FORM, HONESTLY AND CORRECTLY. IF THERE IS ANY CHANGE IN MY HEALTH, MEDICINES, ETC. I WILL INFORM THIS DENTAL OFFICE AT MY NEXT APPOINTMENT OR BEFORE. THIS INFORMATION IS FOR MEDICAL USE ONLY (Per HIPAA Regulations). I ALSO AGREE TO ALLOW THIS CONFIDENTIAL INFORMATION TO BE SHARED WITH PHYSICIANS, HEALTH PROFESSIONALS, REFERRING DENTISTS, CLINICAL AND DENTAL LABORATORIES, PHARMACIES, OR ANY OTHER HEALTH CARE PERSONNEL PROVIDING ME TREATMENT.

DATE: _____ **SIGNATURE OF PATIENT:** _____
(or Parent/Guardian if under age 18)

FOR OFFICE USE ONLY

REVIEWED WITH THE PATIENT ON ___/___/___ **SIGNATURE:**_____