Center For Oral & Maxillofacial Surgery

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Dental History

Patient Name:____ Date:_____________________

Do you have a regular dentist? ☐ Yes ☐ No

If yes, please list their name and phone number: Dr.___________________________Ph#:___________________________

If no, would you like for us to refer you to someone? ☐ Yes ☐ No

Date of your last dental exam: ___________________________________ Date of last full mouth x-ray:_________________

Where was your x-ray taken? ____

	Yes	No
Have you experienced trouble from previous dental care?	☐	☐
Do you have pain in your jaw or near you ears?	☐	☐
Do you have any unhealed injuries or inflamed areas in or around your mouth?	☐	☐
Have you experienced any growths or sore spots in your mouth?	☐	☐
Does any part of your mouth hurt when clenched?	☐	☐
Have you ever had Novocain or other local anesthetic?	☐	☐
Have you ever had Nitrous Oxide (laughing gas)?	☐	☐
Have you ever had General Anesthesia?	☐	☐
Have you ever had any reaction or allergic symptoms to Novocain, local or general Anesthesia?	☐	☐
Have you ever had any difficulty with extractions in the past?	☐	☐
Have you ever had prolonged bleeding following extractions in the past?	☐	☐
Do your gums bleed?	☐	☐
Do you have a bad taste in your mouth or mouth odor?	☐	☐
Have you ever had instructions on the care of your gums?	☐	☐
Do you chew only on one side of your mouth? If so, why?_____________________________________	☐	☐
Do you habitually clench or grind your teeth during the night or day?	☐	☐
Is any part of your mouth sensitive to pressures or irritants (hot, cold or sweets)?	☐	☐

Are there any issues not covered above that you would like to discuss?___________________________________

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Patient Signature/Date   Doctor Signature/ Date

Updated *   Doctor Signature:____Date:___________________