



**DENTAL HISTORY FORM**

**Patient Name:**

**Medical Alert:**

*In order that we may provide you with the best possible care, please complete this dental history form  
All information is completely confidential.*

What is the reason for your visit today?					
Date of last dental visit:		What was done at your last dental visit?			
Last cleaning?					
Last full X-rays?					
Previous Dentist`s name			Phone:		
Address:					
How often do you have dental examinations?			How often do you floss?		
How often do you brush your teeth?					
What other dental aids do you use? Sonicare/ toothpick/ etc.					
Please describe any dental problems you currently have:					
<b>Are your teeth sensitive to:</b>		Hot	Cold	<b>Have you ever had:</b>	
Biting or chewing?		NO	YES	Orthodontic treatment?	NO YES
<b>Do you frequently get:</b>				if yes, do you wear retainers?	NO YES
cold sores?		NO	YES	Oral surgery?	NO YES
Blisters?		NO	YES	Periodontal treatment?	NO YES
Any Oral lesions?		NO	YES	your bite adjusted?	NO YES
Have you noticed any mouth odors or bad taste?		NO	YES	Night guard or mouth guard?	NO YES
				A serious injury to the mouth or head?	NO YES
				If yes, please describe:	
<b>Do your Gums bleed or hurt?</b>					
Have your parents experienced gum diseases or tooth loss?					
Have you noticed any loose teeth or change in your bite?					
Does food tend to become caught in between your teeth? If yes, where?				<b>Have you experienced:</b>	
				Clicking or popping of the jaw?	NO YES
<b>Do you:</b>				Pain? Joint/ ear/ side of face?	NO YES
Clench or grind your teeth while awake or asleep?				Difficulty in opening or closing the mouth?	NO YES
Bite your cheeks or lips frequently?				Difficulty in chewing on either side?	NO YES
Hold objects with your teeth? (pencil. ...)				Sore muscles in your neck or shoulders?	NO YES
Bite your fingernails?)					
Mouth breathe while awake or asleep?					
have you tired jaws especially in the morning?					
Smoke or chew tobacco?					

If you could change something about your smile, what would it be?

Are you interested in using sedation for your appointment?

Is there anything else about dental treatment you would like us to know? If so, please explain: