Patient Name _____ I prefer to be called _____ Date _____

DENTAL HISTORY

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 Name _____
How often do you have dental examinations? _____
How often do you brush your teeth? _____ How often do you floss? _____
Have you ever used or are currently using topical fluoride? Yes No
What other dental aids do you use? (Interplak, toothpick, etc.) _____
Do you have any dental problems now? Yes No
If yes, please describe: _____
Is there anything about your teeth you would like to change? 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 bone loss? Yes No
Have you noticed any loose teeth or change in your bite? Yes No
Does food tend to get caught in between your teeth? Yes No
If yes, where? _____

Do you:

Clench or grind your teeth while awake **o**r asleep? Yes No
Bite your lips or cheeks? Yes No
Hold foreign objects with your teeth? (pencils,pipe,pens,fingernails?) Yes No
Mouth breathe while awake or asleep? Yes No
Have tired jaws? (morning?) Yes No
Snore or have any other sleeping disorders? Yes No
Smoke/chew tobacco or use any 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 mouthguard? 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? Yes No
Headaches, neckaches or shoulder aches? Yes No
Sore muscles (neck, shoulders)? Yes No

Are you satisfied with your teeth's appearance? Yes No
Do you feel nervous about having 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: _____
_____

Have you ever been told to take a premedication prior to dental treatment? Yes No
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)