

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 your 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 _____

