DENTAL HISTORY

Patient Name ____________________

Please complete both sides of this medical/dental history form, so that we may provide you with the best possible care. All information is completely confidential.

What is the reason for today's visit? ____________________

Last Dental Visit __________ **Last Dental Cleaning** __________ **Last Full Mouth X-rays** __________

What procedures were done at your last dental visit? ____________________

Previous Dentist's Name ____________________

Address __________ City __________ State __________ Zip __________

Telephone ____________________

How often do you have dental examinations? ____________________

How often do you brush your teeth? __________ How often do you floss? __________

What other dental aids do you use? (toothpick, Interplak, etc.) ____________________

Do you have any dental concerns now? Yes No

If yes, describe: ____________________

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 so, please describe, including cause ____________________

Are any of your teeth sensitive to:

Sweets?	Yes	No
Biting or Chewing?	Yes	No
Hot or Cold?	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

Have you experienced:

Sore muscles (neck, shoulders)?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Clicking or popping of the jaw?	Yes	No
Headaches, neckaches, or shoulder aches?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No

Do you:

Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Smoke/chew tobacco or use other tobacco products?	Yes	No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Snore or have any other sleeping disorders?	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 get caught in your teeth?	Yes	No

If yes, where? ____________________

Are you satisfied with your teeth's appearance?	Yes	No
Would you like to keep all of your teeth all of your life?	Yes	No
Do you feel nervous about having dental treatment?	Yes	No

If so, what is your biggest concern? ____________________

Have you ever had an upsetting dental experience?	Yes	No

If yes, please describe ____________________

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)