DENTAL HISTORY FORM

Welcome! So that we may provide you with the best possible care please complete our Dental & Medical history forms. Thank You.

All information is completely confidential.

Patient Name: _____Date:_____

What is the reason for your visit today? _____

Date of last Dental Visit: _____ Last dental cleaning: _____

What was done at your last visit? _____

Previous Dentist's Name: _____ Phone Number_____

Address: _____State: _____ Zip Code: _____

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? (interplak, toothpick, etc.) _____

Do you have any dental problems now? ..... Y N

If yes, please describe:

_____

Are any of your teeth sensitive to:

Hot or Cold? …… Y N

Sweets? …… Y N

Biting or Chewing? …… Y N

Have you noticed any mouth odors or bad breath? …… Y N

Do you frequently get cold sores, blisters or any other oral lesions? …… Y N

Do your gums bleed or hurt? …… Y N

Have your parents experienced gum disease or tooth loss? ..... Y N

Have you noticed any loose teeth or change in your bite …… Y N

Does food tend to become caught in between your teeth? …… Y N

if yes where? _____

Do You:

Clench or grind your teeth while your awake or asleep?..... Y N

Bite your lips or cheeks regularly? ..... Y N

Hold foreign objects with your teeth? …… Y N

(pencils, pipe, pins, nails, fingernails? …… Y N

Mouth breathe while awake or asleep? …… Y N

Have tired jaws, especially in the morning? ..... Y N

Snore or have any other sleeping disorders?..... Y N

Smoke/chew tobacco or use other tobacco products?..... Y N

Have you ever had?

Orthodontic treatment? ..... Y N

Oral Surgery?..... Y N

Periodontal treatment? ..... Y N

Your teeth ground or bite adjusted? …… Y N

A bite plane or mouth guard? ..... Y N

A serious injury to the mouth or head? …… Y N

If so, please describe, including cause_____

_____

Have you experienced:

Clicking or popping of the jaw? …… Y N

Pain? (joint, ear, side, or face)? …… Y N

Difficulty in opening or closing the mouth? …… Y N

Difficulty in chewing on either side of the mouth?…… Y N

Headaches, neck aches or shoulder aches? …… Y N

Sore muscles (neck, shoulders)? …… Y N

Are you satisfied with your appearance? …… Y N

Would you like to keep all of your teeth all your life? …… Y N

Do you feel nervous about having dental treatment? …… Y N

If so, what is your biggest concern?

_____

Have you ever had an upsetting dental experience? …… Y N

If yes, please describe_____

Have you ever been told to take a pre-medication prior to dental treatments? Y N

Is there anything else about having dental treatment that you would like us to know?

If yes please describe: _____

_____