

Patient Name
Patient Account No.

DENTAL HISTORY

Medical Alert

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's Name _____

Address _____ 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? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? Yes No

If yes, please describe: _____

Are any of your teeth sensitive to:

Have you ever had:

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

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 _____

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? _____

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 of the mouth? Yes No
 Headaches, neckaches or shoulder aches? Yes No
 Sore muscles (neck, shoulders)? Yes No

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 sleeping disorders? Yes No
 Smoke/chew tobacco or use other tobacco products? Yes No

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)