

Patient Name	DENTAL HISTORY
Patient Account No.	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 _____

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? _____

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 dental problems no? 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
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 object 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

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 _____

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 should aches? Yes No
- Sore muscles (neck, shoulders)? 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

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 _____

Have you ever been told to take a pre-medication 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)