

DENTAL HISTORY

PATIENT NAME _____	MEDICAL ALERT _____
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*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-ray** _____

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 problem 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 between your teeth?

Yes No
If yes, where _____

Do you:

Clench or grind your teeth while awake or asleep?... Yes No

Mouth breathe while awake or asleep?..... Yes No

Have tired jaws, especially in the morning?..... Yes No

Smoke/chew tobacco?..... Yes No

Have you ever had:

Orthodontic Surgery?..... Yes No

Oral Surgery?..... Yes No

Periodontal treatment?

Your teeth ground or the bite adjusted?

A bite plate or mouth guard?

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)

Difficulty in opening or closing the mouth?

Headaches, neckaches or shoulder aches?

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

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)