DENTAL HISTORY

NAME ____ DATE ______________________

Welcome! *So that we can provide you with the best possible care, we ask you to fill out this dental history form.*

All information is completely confidential.

What is the reason for today's visit? ____

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Date of last dental visit? ________________ **Last dental cleaning?** ________________ **Last x-rays?** _______________

What was done at your last dental visit? ____

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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? (Sonicare, toothpicks, etc.) ____

Do you have any dental problems 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 get frequent cold sores, blisters or other oral lesions? Yes No

Do your gums bleed or hurt? *Yes No*

Have your parents experience gum disease? Yes No

Have your parents experienced tooth loss? Yes No

Have you noticed any loose teeth or changes in your bite? Yes No

Does food get caught between your teeth? Yes No

If yes, where? ____________________

Do you:

Clench or grind your teeth during the day? Yes No

Have you ever had:

Clench or grind your teeth at night? Yes No

Bite your lips or cheeks regularly? Yes No

Hold foreign objects with your teeth? (pencil, pipe,, etc.) Yes No

Bite your fingernails? Yes No

Breathe through your mouth at night? Yes No

Breathe through your mouth during the day? Yes No

Snore? Yes No

Have tired jaws, especially in the morning? Yes No

Smoke or chew tobacco? Yes No

Braces? Yes No

Oral surgery? Yes No

Gum treatment? Yes No

A bite plate or mouth guard? Yes No

A serious injury to the mouth or head? Yes No

If so, please describe ____________________

Have you experienced:

Clicking or popping in the jaw? *Yes* *No*

Pain in the jaw joint, ear or side of face? *Yes* *No*

Difficulty in opening or closing the mouth? *Yes* *No*

Headaches, neck aches or shoulder aches? *Yes* *No*

Sore muscles in the neck or shoulders? *Yes* *No*

Are you happy with your smile ? *Yes* *No*

*What would you like to change?*___________________

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Are you nervous about dental treatment? *Yes* *No*

*If so, what is your biggest concern?*________________

Have you ever had a bad dental experience? *Yes* *No*

If yes, please describe ________________________

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Is there anything else about having dental treatment you would like us to know? Please describe ________________

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