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 Month X-rays** _____

What was done at your last dental visit?_____

_____

Previous Dentist's Name_____ State _____ Zip _____

Address_____

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:

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?

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? _____

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? ○Yes ○No
(pencils, pipe, pins, nails, fingernails) ○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 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 of shoulder 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

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)