DENTAL HISTORY

For

Patient Name: ______________________________

What is the reason for your visit today? ______________________________

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Date of last dental visit ______________ Last dental cleaning ______________

What was done at your last dental visit? ______________________________

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Previous Dentist's Name ______________________________

Address ______________________________

Phone ________________ State ____________ Zipcode ____________

How often do you have dental examinations? ______________________________

How often do you brush your teeth? __________ How often do you floss? ______________

What toothpaste do you use? ______________________________

What mouthwash do you use? ______________________________

What other dental aids do you use? ______________________________

Do you have any dental problems now? Yes No If yes, please describe: ______________________________

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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/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 in between your teeth?	Yes	No

If yes, where? ______________________

Do you:

Clench or grind your teeth while awake or sleep?	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 any tobacco products?	Yes	No
Is Whitening your teeth any interest to you?	Yes	No

Have you ever had:

Orthodontic Treatment?	Yes	No
Oral Surgery?	Yes	No
Periodontal Treatment?	Yes	No
Dermafill or Botox?	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 ____________

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

Are you satisfied with your teeth's appearance?	Yes	No
Are you nervous about having dental treatment?	Yes	No

If so what is your biggest concern? ________________

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Have you ever experienced an upsetting dental experience?	Yes	No

If yes, please describe ______________________

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Is there anything else about having dental treatment that you would like us to know?	Yes	No

If yes, please describe ______________________________