DENTAL HISTORY

Patient Name	Medical Alert

Welcome!

In order for us to 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: _________
What was done at your last dental visit? ____

____

Previous Dentist's Name: __________________________ Telephone: _________________________
Address: ____ State: _______ Zip: __________

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? (Electric toothbrush, Water Pick, flosspicks, etc.) ______________

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

Check All That Apply

Are any of your teeth sensitive to:

- ☐ Hot or Cold?
- ☐ Sweets?
- ☐ Biting or Chewing?
- ☐ Have you noticed any mouth odors or bad tastes?
- ☐ Do you frequently get cold sores, blisters, or any other oral lesions?
- ☐ **Do your gums bleed or hurt?**
- ☐ Have you noticed any loose teeth or change in your bite?
- ☐ Does food tend to get caught in between your teeth?
  If yes, where_________________________

Do You:

- ☐ Clench or grind your teeth while awake or asleep?
- ☐ Bite your lips or cheeks regularly?
- ☐ Hold foreign objects with your teeth? (pencils, pins, nails)
- ☐ Mouth breathe while awake or asleep?
- ☐ Have a tired jaw, especially in the morning?
- ☐ Smoke/chew tobacco?

Have you ever had:

- ☐ Orthodontic treatment?
- ☐ Oral surgery?
- ☐ Periodontal treatment?
- ☐ Your teeth ground or the bite adjusted?
- ☐ A night guard or mouth guard?
- ☐ A serious injury to the mouth or head?
  If so, please describe, including cause:
  ____

Have you experienced:

- ☐ Clicking or popping of the jaw?
- ☐ Pain? (joint, ear, side of face)
- ☐ Difficulty in opening or closing the mouth?
- ☐ Difficulty in chewing on either side of the mouth?
- ☐ Headaches, neck aches, or shoulder aches?
- ☐ Sore muscles (neck, shoulders)?
- ☐ **Are you satisfied with your teeth's appearance?** ______________________
- ☐ Would you like to keep all of your teeth for the rest of your life? ____________________
- ☐ Do you feel nervous about having dental treatment? If so, what is your biggest concern?
  ____
- ☐ Have you ever had an upsetting dental experience? If yes, please describe:
  ____

Is there anything else about having dental treatment that you would like us to know?

If yes, please describe: ____

____

(Please complete other side)