Dental History

Patient Name: **Medical Alert:**

In order that we may provide you with the best possible care, please complete this dental history form.
All information is completely confidential.

What is the reason for your visit today?

Date of last dental visit What was done at your last dental visit?
Last cleaning?
Last Full Mouth X-rays?

Previous Dentist's Name 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? Sonicare/ toothpick/ etc.

Please describe any dental problems you currently have:

Are your teeth sensitive to:		**Have you ever had:**	
Hot ?	Yes No	Orthodontic treatment?	Yes No
Cold ?	Yes No	If yes, do you wear retainers?	Yes No
Biting or Chewing?	Yes No	Oral surgery?	Yes No
Do you frequently get:		Periodontal treatment?	Yes No
Cold sores?	Yes No	Your bite adjusted?	Yes No
Blisters?	Yes No	Night guard or mouth guard?	Yes No
Any oral lesions?	Yes No	A serious injury to the mouth or head?	Yes No
Have you noticed any mouth odors or		If yes, please describe.	
bad tastes?	Yes No		
		Have you experienced:	
Do your gums bleed or hurt?	Yes No	Clicking or popping of the jaw?	Yes No
Have your parents experienced gum disease or tooth loss?	Yes No	Pain? joint/ ear/ side of face	Yes No
Have you noticed any loose teeth or change in your bite?	Yes No	Difficulty in opening or closing the mouth?	Yes No
Does food tend to become caught in between your teeth?	Yes No	Difficulty in chewing on either side of the mouth?	Yes No
If yes, where?		Headaches, neckaches or shoulder aches?	Yes No
		Sore muscles in your neck or shoulders?	Yes No
Do you:			
Clench or grind your teeth while awake or asleep?	Yes No	**Do you feel nervous about having dental treatment?**	
Bite your cheeks or lips frequently?	Yes No	If so, what is your biggest concern?	
Hold objects with your teeth: pencils/pens/pins/pipe	Yes No		
Bite your fingernails?	Yes No	Have you ever had an upsetting dental experience?	
Mouth breathe while awake or asleep?	Yes No	If so, please explain	
Have tired jaws especially in the morning?	Yes No		
Smoke or chew tobacco?	Yes No		

Are you satisfied with the appearance of your teeth? If not, what would you change?

Are you interested in using sedation for your appointments?

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

If so, please explain