DENTAL HISTORY

Patient Name: _____

Welcome!! So that we may provide you with the best possible care, please complete this dental history form. All information will be kept 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/Address/Ph Number_____

_____

How often do you have dental examinations?_____

How often do you brush your teeth?_____ How often do you floss? _____

Have you ever used or are currently using topical fluoride? Yes ◯ No◯

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	**YES**	**NO**	***Have you ever had:***	**YES**	**NO**
Hot or cold?	◯	◯	Orthodontic Treatment?	◯	◯
Sweets?	◯	◯	Oral Surgery?	◯	◯
Biting or chewing?	◯	◯	Periodontal Treatment?	◯	◯
Have you noticed any mouth odors or bad tastes?	◯	◯	Your teeth ground or the bite adjusted?	◯	◯
Do you frequently get cold sores, blisters or other oral lesions?	◯	◯	A bite plate or mouth guard?	◯	◯
Do your gums bleed or hurt?	◯	◯	A serious injury to the mouth or head?	◯	◯
Have your parents had gum disease or tooth loss?	◯	◯			
Have you noticed any loose teeth/ change in bite?	◯	◯	***Have you ever experienced:***		
Does food tend to become caught in your teeth?	◯	◯	Clicking or popping of the jaw?	◯	◯
If yes, where?			Pain?(joint, ear, side of face)	◯	◯
Do you:			Difficulty in opening or closing mouth?	◯	◯
Clench or grind your teeth while awake or asleep?	◯	◯	Difficulty in chewing on either side of the mouth?	◯	◯
Bite your lips or cheeks regularly?	◯	◯	Headaches, neck aches or shoulder aches?	◯	◯
Hold foreign objects with your teeth? (pencils, nails, etc.)	◯	◯	Sore muscles (neck, shoulders)?	◯	◯
Mouth breathe while awake or asleep?	◯	◯	Are you satisfied with your teeth's appearance?	◯	◯
Have tired jaws especially in the morning?	◯	◯	Would you like to keep your teeth all of your life?	◯	◯
Snore or have any other sleeping disorders?	◯	◯	Do you feel nervous about having dental treatment?	◯	◯
Smoke/chew tobacco or other tobacco products?	◯	◯	Have you ever had an upsetting dental experience?	◯	◯
Have you ever been told to take a pre-medication prior to your dental treatment? YES◯ NO◯					
Is there anything else about having dental treatments that you would like us to know?					