

DENTAL HISTORY

Patient Name

Patient Account No.

Medical Alert

Welcome! Please complete both sides of this dental/medical history form so that we may provide you with the best possible dental care. 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? _____

Have you ever used or are you 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:

- Hot or cold? Yes No
 - Sweets? Yes No
 - Biting or chewing? Yes No
 - Have you noticed any mouth odors or bad taste? 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 asleep? Yes No
- Bite your lips or cheeks regularly? Yes No
- Hold foreign objects 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 tobacco or use other tobacco products? 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 yes, 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, neck aches or 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 _____

Have you ever been told to take a pre-medication prior to dental treatment? Yes No

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

If yes, please describe _____