

Patient Name \_\_\_\_\_

# DENTAL HISTORY

Medical Alert \_\_\_\_\_

**Welcome!** So that we may provide you with the best possible care, please complete both sides of this medical/dental form. All information is completely **confidential**.

What is the reason for your visit today? \_\_\_\_\_

Date of last dental visit \_\_\_\_\_ Last Dental Cleaning \_\_\_\_\_ Full Mouth X-rays \_\_\_\_\_

What was done at your last visit? \_\_\_\_\_

General Dentist Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ 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 tooth brush, toothpick, etc.) \_\_\_\_\_

Do you have any dental problems now? Yes No

If Yes, please describe: \_\_\_\_\_

**Are you experiencing:**

Sensitivity to hot or cold? \_\_\_\_\_ Yes No

Sensitivity to sweets? \_\_\_\_\_ Yes No

Sensitivity to Biting or Chewing? \_\_\_\_\_ Yes No

Mouth odors or bad taste? \_\_\_\_\_ Yes No

Frequent cold sores, blisters or any other oral lesions? \_\_\_\_\_ Yes No

Bleeding or sore gums? \_\_\_\_\_ Yes No

Loose teeth? \_\_\_\_\_ Yes No

Change in your bite? \_\_\_\_\_ Yes No

Food getting caught in between your teeth? \_\_\_\_\_ Yes No

If yes, where? \_\_\_\_\_

Have your parents experienced gum disease or tooth loss? \_\_\_\_\_ Yes No

**Have you ever experienced:**

Clicking or popping of the jaw? \_\_\_\_\_ Yes No

Pain in the ear, joint, side of face? \_\_\_\_\_ Yes No

Difficulty in opening or closing your mouth? \_\_\_\_\_ Yes No

Headaches, sore muscles (neck and shoulders)? \_\_\_\_\_ Yes No

Are you satisfied with the appearance of your teeth? Yes No

Would like to keep all of your teeth throughout your life? Yes No

Do you feel nervous about receiving dental treatment? Yes No

If so, what is your main concern? \_\_\_\_\_

Have you ever had an upsetting dental experience? Yes No

If so, please describe: \_\_\_\_\_ Yes No

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

If yes, please describe: \_\_\_\_\_

**Comments:** \_\_\_\_\_

**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 breath while awake or asleep? \_\_\_\_\_ Yes No

Have tired jaws, especially in the morning? \_\_\_\_\_ Yes No

Smoke/ chew tobacco? \_\_\_\_\_ Yes No

**Have you ever had:**

Orthodontic treatment? \_\_\_\_\_ Yes No

Oral surgery? \_\_\_\_\_ Yes No

Periodontal treatment? \_\_\_\_\_ Yes No

Your teeth ground or bite adjusted? Yes No

A bite plate or mouth guard? \_\_\_\_\_ Yes No

Serious injury to the mouth or the head? \_\_\_\_\_ Yes No

If yes, please describe below, including cause.