**Patient Name:** _____

# Dental History

*Welcome! So 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** _____ **Last Dental Cleaning** _____ **Last Full Mouth X-rays** _____
What was done at your last dental visit? _____
_____
Previous Dentist's Name _____
Address _____ State _____ Zip _____
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? (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 | Yes | No |
| Any other oral lesions? | Yes | No |
| **Do your gums bleed or hurt?** | Yes | No |
| Have your parents experienced gum disease | Yes | No |
| 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, pins, pipe, nails, fingernails) | Yes | No |
| Mouth breathe 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 the bite adjusted? | Yes | No |
| A bite plate or mouth guard? | Yes | No |
| A serious injury to the mouth or head? | Yes | No |

If so, 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 chewing on either side of the mouth? | Yes | No |
| Difficulty in opening or closing the mouth? | Yes | No |
| Headaches, neckaches 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 _____
_____

Is there anything else about having dental treatment that you would like us to know? Yes No
If yes, please describe _____
_____