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 history form.
All information is completely confidential.

What is the reason for you 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? (water pik, electric toothbrush, toothpick, etc.) _____

Do you have any dental problems now? Yes No
if yes, please describe: _____

Are other teeth sensitive to:

Hot or cold? Yes No
Sweets? Yes No
Biting or Chewing? Yes No
Have you noticed any mouth odors or bad tastes? Yes No
Do you frequently get cold sores, blisters or any oral lesions? Yes No
Do your gums bleed or hurt? Yes No
Have your parents experience gum dieseas or tooth loss? Yes No
Have you noticed any loose teeth or change in your bite? Yes No

Do you?

Clench or grind your teeth while awake or asleep? Yes No
Mouth breath while awake or asleep? Yes No
Have tired jawas, especially in the morning? Yes No
Smoke/chew tabacco? Yes No

Have you ever had:

Orthodontic Treatment? Yes No
Oral surgery? Yes No
Periodontal treatment? 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 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?

Do you like the color of your teeth? Yes No
Are you happy with the size and spacing of your teeth? Yes No
Are you interested in changing your smile? Yes No
Would you like to keep all your teeth all your life? Yes No
Do you feel nervous about having dental treatment? Yes No
If so, what is your biggest concern?_____ Yes No
_____
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 _____
_____
_____

(Please complete other side)