Date: _____

Dental History

Last Name: _____ First Name: _____ Middle Initial: _____

Patient Account No. _____

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: _____City_____State_____Zip_____

How often do you have dental examinations?: _____ How often do you brush? _____

How often do you floss? _____ What other dental aids do you use? (Interplak, toothpick, etc)_____

Do you have any dental problems now? Yes No _____Relationship: _____

If yes, please describe: _____

Dental Questions

Are any of your Teeth Sensitive to:		
Hot or cold?	Yes	No
Sweet?	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 other oral lesions?	Yes	No
Do you gums bleed or hurt?	Yes	No
Have you 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?	Yes	No
Do you:	Yes	No
Clench or grind you teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with you 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
Snore or have any other sleeping disorders?		
Smoke/chew tobacco or use other tobacco products?		

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
Is 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
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 you teeth all of you life?	Yes	No
Do you feel nervous about having dental treatment?	Yes	No
If so, what is you biggest concern? _____	Yes	No
Have you ever had an upsetting dental experience?		
If yes, please describe_____		

Is there anything else about having Dental treatment that you would like us to know?
If yes, please describe _____

_____

_____