Patient Name	Dental History
Patient Account No.	Medical Alert

Welcome! So that we may provide you with the best possible care,
please complete both the dental and medical history forms.
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: _____

Please circle "Yes" or "No" for each item:

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 tastes? 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
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 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: _____
_____

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