

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 Code _____

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: _____

<p>Are any of your teeth sensitive to:</p> <p>Hot or cold? <input type="radio"/> Yes <input type="radio"/> No</p> <p>Sweets? <input type="radio"/> Yes <input type="radio"/> No</p> <p>Biting or chewing? <input type="radio"/> Yes <input type="radio"/> No</p> <p>Have you noticed any mouth odors or bad tastes? <input type="radio"/> Yes <input type="radio"/> No</p> <p>Do you frequently get cold sores, blisters, or any other oral lesions? <input type="radio"/> Yes <input type="radio"/> No</p> <p>Do your gums bleed or hurt? <input type="radio"/> Yes <input type="radio"/> No</p> <p>Have your parents experienced gum disease or tooth loss? <input type="radio"/> Yes <input type="radio"/> No</p> <p>Have you noticed any loose teeth or change in your bite? <input type="radio"/> Yes <input type="radio"/> No</p> <p>Does food tend to become caught in between your teeth? <input type="radio"/> Yes <input type="radio"/> No</p> <p>If yes, where? _____</p> <p>Do you:</p> <p>Clench or grind your teeth while awake or asleep? <input type="radio"/> Yes <input type="radio"/> No</p> <p>Bite your lips or cheeks regularly? <input type="radio"/> Yes <input type="radio"/> No</p> <p>Hold foreign objects with your teeth (pencils, pipe, pins, nails, fingernails)? <input type="radio"/> Yes <input type="radio"/> No</p> <p>Mouth breathe while awake or asleep? <input type="radio"/> Yes <input type="radio"/> No</p> <p>Have tired jaws, especially in the morning? <input type="radio"/> Yes <input type="radio"/> No</p> <p>Smoke/chew tobacco? <input type="radio"/> Yes <input type="radio"/> No</p>	<p>Have you ever had:</p> <p>Orthodontic treatment? <input type="radio"/> Yes <input type="radio"/> No</p> <p>Oral surgery? <input type="radio"/> Yes <input type="radio"/> No</p> <p>Periodontal treatment? <input type="radio"/> Yes <input type="radio"/> No</p> <p>Your teeth ground or the bite adjusted? <input type="radio"/> Yes <input type="radio"/> No</p> <p>A bite plate or mouth guard? <input type="radio"/> Yes <input type="radio"/> No</p> <p>A serious injury to the mouth or head? <input type="radio"/> Yes <input type="radio"/> No</p> <p>If so, please describe, including cause _____</p> <p>Have you experienced:</p> <p>Clicking or popping of the jaw? <input type="radio"/> Yes <input type="radio"/> No</p> <p>Pain (joint, ear, side of face)? <input type="radio"/> Yes <input type="radio"/> No</p> <p>Difficulty in opening or closing the mouth? <input type="radio"/> Yes <input type="radio"/> No</p> <p>Headaches, neckaches, or shoulder aches? <input type="radio"/> Yes <input type="radio"/> No</p> <p>Sore muscles (neck, shoulders)? <input type="radio"/> Yes <input type="radio"/> No</p> <p>Are you satisfied with your teeth's appearance? <input type="radio"/> Yes <input type="radio"/> No</p> <p>Would you like to keep all of your teeth for all of your life? <input type="radio"/> Yes <input type="radio"/> No</p> <p>Do you feel nervous about having dental treatment? <input type="radio"/> Yes <input type="radio"/> No</p> <p>If so, what is your biggest concern? _____</p> <p>Have you ever had an upsetting dental experience? <input type="radio"/> Yes <input type="radio"/> No</p> <p>If yes, please describe: _____</p>
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Is there anything else about having dental treatment that you would like us to know?

Yes No

If yes, please describe: _____
