



## DENTAL HISTORY

So that we may provide you with the best possible care, please complete this form as completely as possible.

Patient Name: \_\_\_\_\_ Medical Alert: \_\_\_\_\_

What is the reason for today's visit? \_\_\_\_\_

Date of last dental visit \_\_\_\_\_ Reason \_\_\_\_\_

Date of last cleaning \_\_\_\_\_ Date of last x-rays \_\_\_\_\_

Previous dentist's name \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_ Phone \_\_\_\_\_

How often do you have dental check-ups? \_\_\_\_\_

How often do you brush? \_\_\_\_\_ floss? \_\_\_\_\_

What dental aids do you use? \_\_\_\_\_

What dental problems do you have now? \_\_\_\_\_

**Are any of your teeth sensitive to: (please check)**

hot or cold? Yes No

sweets? Yes No

biting or chewing? Yes No

Do you get cold sores or other oral lesions? Yes No

**Do you notice mouth odors or bad tastes?** Yes No

Do your gums bleed or hurt? Yes No

Do you notice any loose teeth or change in your bite? Yes No

Does food tend to get caught in your teeth? Yes No

Do you smoke or chew tobacco? Yes No

**Do you clench or grind while awake or asleep?** Yes No

Do you mouth breath while awake or asleep? Yes No

Have you noticed clicking or popping of the jaw? Yes No

Do you have difficulty opening or closing? Yes No

Do you have pain or difficulty chewing? Yes No

Do you have tired jaws, especially in the morning? Yes No

**Are you satisfied with the appearance of your teeth?** Yes No

Rate your smile (on a scale of one to ten) \_\_\_\_\_

Would you like to keep all of your teeth for life? 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

Your teeth ground or bit adjusted? Yes No

Pain in jaw, joint, ear or side of face? Yes No

**Do you feel nervous about today's treatment?** \_\_\_\_\_

What is your biggest concern? \_\_\_\_\_

What did you like best at your last dental office? \_\_\_\_\_

What did you like least? \_\_\_\_\_

Have you ever had an upsetting dental experience? Yes No

If so, what was it? \_\_\_\_\_

Is there anything else we should know? Yes No

Please rank the following in the order in which they would

KEEP YOU from having treatment:

Fear of pain \_\_\_\_ Cost of treatment \_\_\_\_ Lack of concern \_\_\_\_

Missing time from work \_\_\_\_ Embarrassed by current condition \_\_\_\_

(Please complete other side)