DENTAL HISTORY

What is the reason for your visit today? _____

Do you have any questions or concerns we can help you with today? _____

Date of Last Dental Visit? _____ Last Dental Cleaning? _____ Last Full Mouth X-rays? _____

What was done at your last dental visit? _____

Name of previous dentist: _____ Phone #: _____

Are you satisfied with your teeth's appearance? Yes No
If no, what would you like to change: _____

Do you feel nervous about having dental treatment? Yes No
If yes, what is your biggest concern: _____

Have you ever had an upsetting dental experience? Yes No
If yes, please describe? _____

How often do you brush your teeth: _____
How often do you floss your teeth: _____
What other dental aids do you use (waterpik, toothpick, etc.):
_____

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

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 yes, please describe _____

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, neck aches or shoulder aches	Yes	No
Sore muscles (neck or shoulders)	Yes	No

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.

_____ Signature

_____ Date

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA