

DENTAL HISTORY

PATIENT NAME: _____

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: _____

Previous Dentist's Name: _____

Address: _____

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? (Waterpik, tooth pick, ect.) _____

Do you have dental problems now? Yes No

If yes please describe: _____

Are any of your teeth sensitive to:

Hot or cold? Yes No

Sweets? Yes No

Biting or chewing? Yes No

Do you frequently get cold sores,
blisters or any other 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? Yes No

Have you noticed any change in your bite? Yes No

Does food tend to become caught
between your teeth? Yes No

If so, where? _____

Do you:

Clench or grind your teeth
while awake or sleeping? Yes No

Bite your lips or cheek regularly? Yes No

Hold foreign objects with your
teeth (pencils, pipe, pins, nails)? Yes No

Mouth breathe while awake or asleep? Yes No

Have tired jaw? Yes No

Smoke or chew tobacco? Yes No

If yes, how many packs a day? _____

Have you ever had:

Orthodontic treatments? (braces) Yes No

Oral surgery? Yes No

Periodontal treatment? (treatment for gums) 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 your mouth? Yes No

Difficulty in chewing on either side? Yes No

Are you satisfied with your teeth's appearance? Yes No

If not, what would you like to change?

Would you like to keep all your teeth all your life? Yes No

Do you feel nervous about having dental treatments? Yes No

If so, what is your biggest concern?

Have you ever had an upsetting dental experience? Yes No

If so, please describe: _____

Is there anything else about having dental treatment that you would like for us to know? Yes No

If so, please describe: _____