

DENTAL HISTORY

Patient Name: _____

What is the reason for your visit today? _____

Date of last Dental visit? _____ Last Cleaning? _____ Last Full mouth x-rays? _____

What was done at your last dental visit? _____

Name of your previous Dentist? _____

Do you have Dental problems now? _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____

How often do you floss your teeth? _____

Do you use a: water-pik, toothpick, electric toothbrush, other? _____

Which of the following apply to you?

Are any of your teeth sensitive to:

- Hot or cold
- Sweets
- Biting or chewing
- Do you have mouth odors or a bad taste
- Cold sores, blisters, other oral lesions

Do you:

- Clench/grind teeth (while awake or asleep)
- Bite lips or cheeks regularly
- Hold foreign objects with your teeth (pencils, etc)
- Mouth breath while awake or asleep
- Have tired jaws, especially in the morning
- Smoke or chew tobacco

Have you ever had:

- Orthodontic treatment
 - Oral surgery
 - Periodontal treatment
 - Your teeth ground or the bite adjusted
 - A bite plate or mouth guard
 - Had a serious injury to the mouth or head
- If so please describe, including cause

Do your gums bleed or hurt?

- Gum Pain or bleeding
- Loose teeth or change in bite
- Food caught/stuck between teeth
- Parental history of gum disease
- Parental history of tooth loss

Have you ever experienced:

- Clicking or popping of jaw
- Pain (joint, ear, side of face)
- Difficulty in opening or closing the mouth
- Difficulty in chewing on either side of the mouth
- Headaches, neck aches or shoulder aches
- Sore muscles (neck, shoulders)

Do you feel nervous about having dental treatment? No Yes If yes, explain _____

Do you have any concerns about dental treatment? No Yes If yes, explain _____

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

Is there anything standing in the way of you getting necessary dental treatment? No Yes If yes, explain _____

My main concerns are: _____

What would you like us to know about? _____

Who may we contact in case of emergency? Name _____

Relationship _____ Primary Phone _____ Secondary phone _____

Comments: _____