Patient Name

DENTAL HISTORY

Patient Account No.

Medical Alert

Welcome! Please complete both sides of this dental/medical history form so that we may provide you with the best possible dental care.

All information is completely confidential.

What is the reason for your visit today? ____________________

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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 ____________________ Telephone ____________________

Address ____________________ State __________ Zip __________

How often do you have dental examinations? ____________________

How often do you brush your teeth? ____________________ How often do you floss? ____________________

Have you ever used or are you currently using topical fluoride? ☐ Yes ☐ No

What other dental aids do you use (Interplak, toothpick, etc.)? ____________________

Do you have any dental problems now? ☐ Yes ☐ No

If yes, please describe: ____________________

Are any of your teeth sensitive to:

	Yes	No
Hot or cold?	☐	☐
Sweets?	☐	☐
Biting or chewing?	☐	☐
Have you noticed any mouth odors or bad taste?	☐	☐
Do you frequently get cold sores, blisters or any other oral lesions?	☐	☐
Do your gums bleed or hurt?	☐	☐
Have your parents experienced gum disease or tooth loss?	☐	☐
Have you noticed any loose teeth or change in your bite?	☐	☐
Does food tend to become caught in between your teeth?	☐	☐

If yes, where? ____________________

Do you:

	Yes	No
Clench or grind your teeth while awake or asleep?	☐	☐
Bite your lips or cheeks regularly?	☐	☐
Hold foreign objects with your teeth (pencils, pipe, pins, nails, fingernails)?	☐	☐
Mouth breathe while awake or asleep?	☐	☐
Have tired jaws, especially in the morning?	☐	☐
Snore or have any other sleeping disorders?	☐	☐
Smoke/chew tobacco or use other tobacco products?	☐	☐

Have you ever had:

	Yes	No
Orthodontic treatment?	☐	☐
Oral surgery?	☐	☐
Periodontal treatment?	☐	☐
Your teeth ground or the bite adjusted?	☐	☐
A bite plate or mouth guard?	☐	☐
A serious injury to the mouth or head?	☐	☐

If yes, please describe, including cause ____________________

Have you experienced:

	Yes	No
Clicking or popping of the 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)?	☐	☐
Are you satisfied with your teeth's appearance?	☐	☐
Would you like to keep all of your teeth all of your life?	☐	☐
Do you feel nervous about having dental treatment?	☐	☐

If so, what is your biggest concern? ____________________

	Yes	No
Have you ever had an upsetting dental experience?	☐	☐

If yes, please describe ____________________

Have you ever been told to take a pre-medication prior to dental treatment? ☐ Yes ☐ No

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

If yes, please describe ____________________

PLEASE COMPLETE OTHER SIDE