Dental History

Patient Name:	
Patient Account No.	Medical Alert

What is the reason for your visit today?____
____
Date of last Dental Visit_________ Last Dental Cleaning ____________ Last Full Mouth X-ray_________
What was done at your last dental visit?____
____
Previous Dentist Name____
Address____State______Zip_________________
Telephone (   )____
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 currently using topical fluoride? Yes No
What other dental aids do you use? (Toothpicks, Interplak, Etc.)___________________________________
____
Do you have any dental problems now? Yes No
If yes, please discribe____

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 lesions?	Yes	No
Do your gums bleed or hurt?	Yes	No
Have your parents experienced gum disease or tooth lose?	Yes	No
Does food tend to become caught in between teeth?	Yes	No

If yes, Where?_________________________________

Do You:

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

Have you ever Had:

Orthodontic treatment	Yes	No
Oral Surgery	Yes	No
Periodontal treatment?	Yes	No
You 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 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 opening or closing the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neck aches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No
Are you satisfied with your teeth's appearance?	Yes	No
Would you like to keep all of your teeth all of your life?	Yes	No
Do you feel nervous about having dental treatment?	Yes	No

If so what is your biggest concern?____________
____

Have you ever had an upsetting dental experience?	Yes	No

If yes, please describe___________________________

Have you ever been told to take pre-medication prior to dental treatment?	Yes	No
Is there anything else about dental treatment that you would like us to know?	Yes	No

If yes, please describe____