| Patient Name | DENTAL HISTORY |
|---|---|
| Patient Account No. | Medical Alert |

*Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. 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** _____

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 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:**

| | | |
|---|---|---|
| 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, etc.) | 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 |
| 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 |

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 the mouth? | Yes | No |
| Difficulty in chewing on either side of the mouth? | Yes | No |
| Headaches, neckaches 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 replace your silver fillings? | 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

Please describe _____

Have you ever had an upsetting dental experience? Yes No

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)