Patient Name

Dental History

Medical Alert

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 a topical fluoride? ..... Yes No

What other dental aids do you use? (Waterpik, 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

Do foods 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 sleep? .....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, Neck aches or shoulder aches? .....Yes No

Sore Muscles (neck, shoulders)? ..... Yes No

Are you satisfied with your teeth's appearance?

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 _____