Patient Name	**DENTAL HISTORY**
Patient Account No.	Medical Alert

Welcome! So that we may provide you with the best possible care please
Please complete both sides of this medical/dental history form.
All the information is completely confidential.

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's Name _____

Address_____State_____Zip_____

Telephone_____

How often do you have dental examinations?_____

How often do you brush your teeth?_____How often do you floss?_____

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 gum?	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, pins, nails, fingernails)	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Smoke/chew tobacco?	Yes	No

Have you ever had:		
Orthodontic treatment?	Yes	No
Oral surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bit 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 in opening or closing 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?	Yes	No

_____

Have you ever had an upsetting dental experience? Yes No

If yes, please describe_____
_____

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

If yes, please describe_____

_____

_____