Patient Name:
Patient Account Number:

DENTAL HISTORY

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 the 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?	☐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 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 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, shoulder)?	☐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?
If yes, please describe:

_____

_____

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

If yes, please describe:

_____

_____