DENTAL HISTORY

What is the Reason for Your Visit Today? ____________________

Previous Dentist's Name ____________________ Address ____________________

Date of Last Visit ____________ Last Hygiene (Cleaning) Visit ____________ Last X-Rays ____________

How often do you have dental examinations? ____________________

How often do you brush your teeth? ____________________ How often do you floss? ____________

What other aids do you use? (Electric toothbrush, toothpick, etc) ____________________

Are any of your teeth sensitive to:

Hot or Cold?	☐ Yes	☐ No
Sweets?	☐ Yes	☐ No
Biting or pressure?	☐ Yes	☐ No
Have you ever noticed any mouth odors or bad taste?	☐ Yes	☐ No
Do you frequently get cold sores, blisters or any 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 between your teeth?	☐ Yes	☐ No

Do you:

Clench or grind your teeth while awake or asleep?	☐ Yes	☐ No
Have tired jaws, especially in the morning?	☐ Yes	☐ No
Bite your lips or cheeks regularly?	☐ Yes	☐ No
Hold foreign objects with your teeth? (pencils, pins, nails, fingernails, pipe)	☐ Yes	☐ No
Mouth breathe while asleep or awake?	☐ Yes	☐ No
Snore?	☐ Yes	☐ No
Do you use a CPAP machine?	☐ Yes	☐ No

Have you ever 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
Frequent headaches, neck aches, or shoulder aches?	☐ Yes	☐ No
Any pain or soreness in the muscles of your face or around the ears?	☐ Yes	☐ No

Have you ever had:

Orthodontic treatment?	☐ Yes	☐ No
Oral Surgery?	☐ Yes	☐ No
Teeth removed?	☐ Yes	☐ No
If so, have they been replaced	☐ Yes	☐ No
Are you happy with their replacement?	☐ Yes	☐ No
Removable Partial?	☐ Yes	☐ No
Complete Denture?	☐ Yes	☐ No
Fixed Bridge?	☐ Yes	☐ No
Implants?	☐ Yes	☐ No
Periodontal Treatment?	☐ Yes	☐ No
Gum Surgery?	☐ Yes	☐ No

If so, when? ____________

By whom? ____________

Your teeth ground or the bite adjusted?	☐ Yes	☐ No
A serious injury to the head or jaws?	☐ Yes	☐ No

If so, please describe. Include cause

____

____

Do you like the appearance of your teeth/smile?	☐ Yes	☐ No
Do you like the color of your teeth?	☐ Yes	☐ No
Are your teeth as straight as you would like?	☐ Yes	☐ No

What would you like to change most in the appearance of your teeth?

____

____

Do you feel anxiety about having dental treatment?	☐ Yes	☐ No
Have you ever had an upsetting dental experience?	☐ Yes	☐ No

If yes, please describe,

____

How did you overcome your anxiety?

____

Is there anything else about having dental treatment that you would like us to know? Please describe ____________

____

____

Do you have any other dental problems? ☐ Yes ☐ No
If yes, please describe ____________________

I consent to the doctor's examination and necessary diagnostics for treatment including X-rays

Patient Signature ____________________ Date ____________

(PARENT/GUARDIAN OF A MINOR)

Reviewed by ____________________ Date ____________