Patient Name	DENTAL HISTORY
Patient Account No.	Medical Alert

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 _____

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 senstive to:			**Have you ever had:**		
Hot or cold?	Yes	No	Orthodontic treatment?	Yes	No
Sweets?	Yes	No	Oral Surgery?	Yes	No
Biting or Chewing?	Yes	No	Periodontal treatment?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No	Your teeth ground or the bite adjusted?	Yes	No
Do you frequently get cold sores, blisters or any other oral lesions?	Yes	No	A bite plate or mouth guard?	Yes	No
			A serious injury to the mouth or head?	Yes	No
Do your gums bleed or hurt?	Yes	No	If so, please describe, including cause _____		
Have your parents experienced gum disease or tooth loss?	Yes	No	**Have you experienced:**		
Have you noticed any loose teeth or change in your bite?	Yes	No	Clicking or popping of the jaw?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No	Pain? (joint, ear, side of face)	Yes	No
			Difficulty in opening or closing the mouth?	Yes	No
If yes, where? _____			Difficulty in chewing on either side of the mouth?	Yes	No
			Headaches, neckaches or shoulder aches?	Yes	No
Do you:			Sore muscles (neck, shoulders)?	Yes	No
Clench or grind your teeth while awake or asleep?	Yes	No	**Are you satisfied with your teeth's appearance?**	Yes	No
Bite your lips or cheeks regularly?	Yes	No	Would you like to keep all of your teeth all of your life?	Yes	No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	Yes	No	Do you feel nervous about having dental treatment?	Yes	No
Mouth breathe while awake or asleep?	Yes	No	If so, what is your biggest concern?		
Have tired jaws, especially in the morning?	Yes	No	_____		
Snore or have any other sleeping disorders?	Yes	No	Have you ever had an upsetting dental experience?	Yes	No
Smoke/chew tobacco or use other tobacco products?	Yes	No	If yes, please describe _____		
			_____		

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)

1.800.925.2600