



Health Information

Side 1

Patient Name: _____ Date: _____ Account No.: _____

Welcome! Our goal is to provide you with the best possible dental care. In order to help us meet all your dental needs, please complete both sides of this form. If you have questions, we will be glad to help you. **All information is confidential.**

Dental History

What is the reason for today's dental visit: _____

Former Dentist and Location: _____

Date of last dental visit: _____ Date of last Full Mouth x-rays: _____

What was done at your last dental visit? _____

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

What other dental aids do you use? (e.g. mouthrinse, waterpik): _____

Do you have any dental problems now?Yes No If yes, please describe: _____

If you could change anything about your smile, what would it be? _____

Would you like to: (please check all that apply) whiten your teeth replace missing teeth replace fillings

straighten your teeth change the overall appearance of your teeth keep all your teeth all your life

Are any of your teeth sensitive to:	Y	N	Have you noticed:	Y	N	Do you have:	Y	N	Have you ever had:	Y	N
Cold?			Bleeding or sore gums?			Mouth odors or bad taste?			Periodontal (gum) treatment?		
Hot?			Any loose teeth?			Mouth Sores or Growths?			Dental Implants?		
Sweets?			Any changes in your bite?			Difficulty to open/close?			Orthodontic treatment?		
Pressure?			Food stuck between teeth?			Habit of biting cheeks/lips?			Oral Surgery/Extractions?		
Chewing?			Swelling of your gums?			Frequent headaches?			Cold sores/Fever Blisters?		
Biting down?			Your Jaw clicks or pops?			Jaw Pain?			Serious oral or head injury?		
Air?			Teeth Grinding/Clenching?			Pain on ear or side of face?			Oral Cancer?		

Do you use tobacco or smoke?Yes No

If yes, how much and how often? (e.g. 1 pack a day): _____

Have your parent(s) experienced gum disease and tooth loss?Yes No

Do you have a nightguard that you wear to sleep?Yes No

Have you ever had an upsetting dental experience?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)