

DENTAL HISTORY

Patient Name: \_\_\_\_\_

*Welcome! In order for us to provide you with the best possible care,  
please complete both pages of this medical/ dental history form.  
All information is completely confidential.*

What is the reason for you 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: \_\_\_\_\_

Telephone: \_\_\_\_\_

How often do you have dental examinations? \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_

What dental hygiene aids do you use? (floss, electronic toothbrush, 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 bad odors or tastes? Yes No

Do you get sores or other mouth lesions? Yes No

Do your gums bleed or hurt? Yes No

Have your parents had gum disease or tooth loss? Yes No

Any loose teeth or change in your bite? Yes No

Does food catch between your teeth? Yes No

If yes, where? \_\_\_\_\_

Do you:

Clench or grind your teeth, awake or asleep? Yes No

Bite your lips or cheeks often? Yes No

Hold things with your teeth (pen, fingernails) Yes No

Breathe through your mouth? Yes No

Have tired jaws? Yes No

Have you ever had:

Orthodontic treatment Yes No

Oral surgery Yes No

Periodontal treatment Yes No

Your bite adjusted Yes No

A bite plate or mouth guard Yes No

Serious mouth or head injury Yes No

If so, please describe \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Have you ever experienced:

Clicking or popping of the jaw? Yes No

Pain in joint, ear, side of face? Yes No

Hard to open or close mouth? Yes No

Difficulty chewing on one side? Yes No

Headaches or neck pain? Yes No

Are you satisfied with your teeth's appearance? (please elaborate) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Would you like to keep all your teeth all your life? Yes No

Are you nervous about dental treatment? Yes No

Have you had any upsetting dental experience? Yes No

If yes, please describe \_\_\_\_\_

What is your biggest dental concern? \_\_\_\_\_

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

If yes, please describe \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

(please complete next page)

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