

DENTAL HISTORY

What is the reason for your dental visit today? _____

Date of last Dental Visit: _____ Last Dental Cleaning: _____ Last Full Mouth X-Rays: _____

What was done at your last dental visit? _____

Previous Dentists Name: _____

Address: _____

Telephone: _____

Do you have any dental problems now: Yes No

If yes, please describe: _____

Are any of your teeth sensitive to Hot: Yes No

Have you ever had:

Are any of your teeth sensitive to Cold: Yes No

Orthodontic (Braces) Treatment: Yes No

Are any of your teeth sensitive to Sweets: Yes No

Oral Surgery: Yes No

Have you noticed any mouth odors or bad tastes in your mouth: Yes No

Periodontal (Gum) Treatment: Yes No

Do you frequently get cold sores, blisters or any other oral lesions: Yes No

Your teeth ground or bite adjusted: Yes No

Do your gums bleed or hurt: Yes No

A bite plate or Mouthguard: Yes No

Have your parents experienced gum disease or tooth loss: Yes No

A serious injury to your mouth or head: Yes No

If yes please describe: _____

Have you noticed any loose teeth or changes in your bite: Yes No

Have you experienced:

Popping or Clicking of the jaw joint: Yes No

Does food tend to become caught in between your teeth: Yes No

Pain in the ear, joint or side of face: Yes No

If so, where: _____

Difficulty opening or closing mouth: Yes No

Headaches, Neck Aches or Shoulder Aches: Yes No

Do You:

Sore Muscles (Back, Hips, Joints): Yes No

Clench or Grind your teeth while awake: Yes No

Are you satisfied with the appearance of your teeth: Yes No

Clench or Grind your teeth while asleep: Yes No

On a scale of 1-10 (10=high, 1=low), rate your smile: _____

Bite your lips or cheeks regularly: Yes No

Do you feel nervous about having dental treatment: Yes No

Have tired jaws (especially in the am): Yes No

If so, what is your biggest concern: _____

Smoke or Chew Tobacco: Yes No

Have you ever had a bad dental experience: Yes No

Is there anything else about having dental treatment that you would like us to know: _____

If so, please explain: _____