

Blackstone Valley Dental Associates

Dental History

Patient Name: _____

Medical alert (office use): _____

Last dental visit _____ What was done at that appointment? _____

Last cleaning _____ Last full mouth X-rays _____

Previous Dentist's Name: _____ Phone: _____

Address: _____

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? (Interlak, toothpick, etc.,) _____

Sensitivity:

Hot or Cold? Yes No

Sweets? Yes No

Biting or Chewing? Yes No

Do you have any dental problems now? Yes No

If yes, please describe: _____

Have you noticed any mouth odors or bad taste? Yes No

Do your gums bleed or hurt? Yes No

Have you noticed any loose teeth or change in your bite? Yes No

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

If yes, Where? _____

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

Bite your lips or cheeks regularly? Yes No

Mouth breath while awake or asleep? Yes No

Smoke or chew tobacco? Yes No

Braces? Yes No

Oral Surgery? Yes No

Gum Surgery? Yes No

Sport or mouth guard? Yes No

Serious injury to the mouth or head? Yes No

If yes, Please describe, including cause _____

Clicking or popping of the jaw? Yes No

If yes, location: _____

Pain? (Joint, ear, or side of face) Yes No

If yes, location: _____

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

Do you feel nervous about having dental treatment? Yes No

If yes, what is your biggest concern? _____

Have you ever had an upsetting dental experience? Yes No

If yes, please describe? _____

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

If yes, please describe: _____

Thank you for providing accurate information that will better help us provide the best possible care. All information is completely confidential.