| Patient Name | |
|---|---|
| Patient Account No. | Medical Alert |

# DENTAL HISTORY

*Welcome! So that we may provide you the best possible care*
*please complete both sides of this medical/ dental 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? _____

Have you ever used or are currently using topical fluoride? Yes No

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 sensitive to:**

| | | |
|---|---|---|
| Hot or cold? | Yes | No |
| Sweets? | Yes | No |
| Biting or Chewing? | Yes | No |
| Have you noticed any mouth odors or bad tastes? | Yes | No |
| Do you frequently get cold sores, blisters or any other oral lesions? | Yes | No |
| Do you gums bleed or hurt? | Yes | No |
| Have you parents experienced gum disease or tooth loss? | Yes | No |
| Have you noticed any loose teeth or change in your bite? | Yes | No |
| Does food tend to become caught in your teeth? | Yes | No |

If yes, where? _____

**Do you:**

| | | |
|---|---|---|
| Clench or grind your teeth while awake or asleep? | Yes | No |
| Bite your lips or cheeks regularly? | Yes | No |
| Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails) | Yes | No |
| Mouth breathe while awake or asleep? | Yes | No |
| Have tired jaw, especially in the morning? | Yes | No |
| Snore or have any other sleeping disorder? | Yes | No |
| Smoke/chew tobacco or use other tobacco products? | Yes | No |

**Have you ever had:**

| | | |
|---|---|---|
| Orthodontic Treatment? | Yes | No |
| Oral Surgery? | Yes | No |
| Periodontal Treatment? | Yes | No |
| Your teeth ground or your bite adjusted? | Yes | No |
| A bite plate or mouth guard? | Yes | No |
| A serious injury to your mouth or head? | Yes | No |

If yes, please describe, including cause _____

_____

**Have you experienced:**

| | | |
|---|---|---|
| Clicking or popping of the jaw? | Yes | No |
| Pain (joint, ear, side of face)? | Yes | No |
| Difficulty in opening or closing the mouth? | Yes | No |
| Difficulty in chewing on either side of the mouth? | Yes | No |
| Headaches, neckaches, or shoulderaches? | Yes | No |
| Sore muscles (neck, shoulders)? | Yes | No |

| | | |
|---|---|---|
| **Are you satisfied with your teeth's appearance?** | Yes | No |
| Would you like to keep all your teeth all your life? | Yes | No |
| Do you feel nervous about having dental treatment? | Yes | No |
| If yes, what is your biggest concern? | Yes | No |

_____

Have you ever had an upsetting dental experience? Yes No

If yes, please describe _____

Have you ever been asked to take a pre-medication prior to dental treatment?..... Yes No

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

If yes, please describe _____

_____