DENTAL HISTORY

***Welcome!*** *So that we may provide you with the best possible care*

*please complete this medical/dental history form.*

*All information is completely confidential.*

Who may we thank for your referral? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the reason for your visit today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Date of last dental visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last dental cleaning \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last full mouth x-rays? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What was done at your last dental visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Previous dentist’s name? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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? (Interplak, toothpick, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a dental problem now? Yes No

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

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| --- | --- | --- | --- |
| **Are any of your teeth sensitive to:**  Hot or Cold?  Sweets?  Biting or chewing?  Have you noticed any mouth odors or bad tastes?  Do you frequently get cold sores, blisters, or any other oral lesions?  Do your gums bleed or hurt?  Have your parents experienced gum disease or tooth loss?  Does food tend to become caught in between your teeth?  **Do you:**  Clench or grind your teeth while awake or asleep?  Bite your lips or cheeks regularly?  Hold foreign objects with your teeth?  Snore or have any other sleeping disorders? | Yes No  Yes No  Yes No  Yes No  Yes No  Yes No  Yes No  Yes No  Yes No  Yes No  Yes No  Yes No | **Have you ever had:**  Orthodontic Treatment?  Oral Surgery?  Periodontal treatment?  Your teeth ground or the bite adjusted?  A bite plate or mouth guard?  A serious injury to the mouth or head?  If so, please describe, including cause \_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Have you experienced:**  Clicking or popping of the jaw?  Pain? (joint, ear, side of face)  Difficulty in opening or closing the mouth?  Difficulty in chewing on either side of the mouth?  Headaches, neck aches or shoulder aches?  Sore muscles (neck, shoulders)?  **Are you satisfied with your teeth’s appearance?**  Would you like to keep all of your teeth all of your life? | Yes No  Yes No  Yes No  Yes No  Yes No  Yes No  Yes No  Yes No  Yes No  Yes No  Yes No  Yes No  Yes No  Yes No |

Do you feel nervous about having dental treatment? Yes No

If yes, please what is your biggest concern? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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?

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