



DENTAL HISTORY

PATIENT: _____

DATE: _____ MED ALERT: _____

1 What is the reason for your visit today? _____

2 Please provide Date:

Last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth Radiographs (x-rays) _____

3 What was done at your last visit? _____

4 Previous Dentist's Name _____

Address: _____

Phone: _____

5 How often do you have dental examinations? _____

6 How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids to you use? (Interplak, toothpick, etc) _____

7 Please describe any immediate dental issues/ problems: _____

8 Please answer the following questions regarding your oral health:

Are any of your teeth sensitive to:

Hot or Cold? Yes No

Sweets? Yes No

Biting or Chewing? Yes No

Do you:

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

Bite your lips or cheek regularly? Yes No

Hold objects with your teeth (i.e. pens, nails, etc)? Yes No

Mouth breathe while awake or asleep? Yes No

Smoke or chew tobacco? Yes No

Have you ever experienced:

Clicking or popping in your jaw? Yes No

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

Tired jaws, especially in the morning? Yes No

Difficulty in opening or closing your mouth? Yes No

Headaches, neck aches, or shoulder aches? Yes No

Sore neck or shoulder muscles? Yes No

Mouth odors or prolonged bad tastes? Yes No

Cold sores, blisters or any other oral lesion? Yes No

Have you ever had:

Your teeth ground or your bite adjusted? Yes No

A bite plate or a mouth guard? Yes No

A serious injury to your mouth or head? Yes No

Orthodontic treatment? Yes No

Oral Surgery? Yes No

Periodontal treatment? Yes No

Other Important Questions:

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

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

Do your gums bleed or hurt? Yes No

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

Are you satisfied with your teeth's appearance? Yes No

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

Do you feel nervous about having dental treatment? Yes No

Have you ever had an upsetting dental experience? Yes No

Smile Evaluation:

Are you pleased/ confident with the way your teeth look when you smile? Yes No

Do you have unwanted spaces between your teeth? Yes No

Is there a chip or crack that you want restored? Yes No

Are you concerned about any discolored teeth? Yes No

Do you have teeth that are overlapping, out of line, or protruding? Yes No

Do you have missing teeth that should be replaced? Yes No

Could your smile be improved if your teeth were:

Whiter? Yes No

Longer? Yes No

Shorter? Yes No

Wider? Yes No

Narrower? Yes No

9 Please describe anything else about your dental health or having dental treatment that you would like us to know: _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. I am aware that all information is confidential.

Patient/ Guardian Signature: _____

Date: _____