

DENTAL HISTORY

What is the reason for your visit today? _____
Previous Dentist's Name _____ Address _____
Date of Last Visit _____ Last Hygiene Visit _____ Last X-Rays _____
How often do you have dental examinations? _____
How often do you brush your teeth? _____ How often do you floss? _____
What other aids do you use? (Electric toothbrush, toothpick, etc.) _____
Do you have any dental problems? Yes No
If yes, please describe _____

Are any of your teeth sensitive to:
Hot or Cold? Yes No
Sweets? Yes No
Biting or pressure? Yes No
Have you ever noticed any mouth odors
or bad taste? Yes No
Do you frequently get cold sores,
blisters or any lesions? Yes No
Do your gums bleed or hurt? Yes No
Have your 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
between your teeth? Yes No

Do you:
Clench or grind your teeth while awake or asleep?..... Yes No
Have tired jaws, especially in the morning? Yes No
Bite your lips or cheeks regularly? Yes No
Hold foreign objects with your teeth?
(pencils, pins, nails, fingernails, pipe) Yes No
Mouth breath while asleep or awake? Yes No
Snore? Yes No

Have you ever experienced:
Clicking or popping of the jaw? Yes No
Pain? (Joint, ear, side of face) Yes No
Difficulty opening or closing the mouth? Yes No
Frequent headaches, neckaches,
or shoulder aches? Yes No
Any pain or soreness in the muscles of
your face or around the ears? Yes No

Have you ever had:
Orthodontic treatment?..... Yes No
Oral surgery? Yes No
Teeth removed? Yes No
If so, have they been
replaced? Yes No
Fixed Bridge? Yes No
Removable Partial? Yes No
Complete Denture? Yes No
Implants? Yes No
Are you happy with the replacement? Yes No
Periodontal Treatment? Yes No
Gum Surgery? Yes No
If so, when?
By whom?
Your teeth ground or the bite adjusted? Yes No
A serious injury to the mouth or head? Yes No
If so, please describe. Include cause. _____

Do you like the appearance of your teeth;
your smile? Yes No
Do you like the color of your teeth? Yes No
Are your teeth as straight as you would like? Yes No
What would you like to change most in the
appearance of your teeth? _____

Do you feel anxiety about having dental treatment? Yes No
Have you ever had an upsetting
dental experience? Yes No
If yes, please describe, _____

How did you overcome your anxiety? _____

Is there anything else about having dental treatment that you would like us to know, please describe. _____

DR. COMMENTS:

I consent to the doctor's exam and necessary diagnostics for treatment including x-rays.

Patient Signature _____ (PARENT/GUARDIAN OF A MINOR) Date _____

Doctor Signature _____ Date _____