Dental History

Patient Name _____Medical Alert_____
What is the reason for your visit today?_____

Date of Last: Dental Visit _____Dental Cleaning _____Full Mouth X-Rays_____
Previous Dentist's Name_____ Address_____
City _____State___ Zip_____ Phone_____

How often do you have dental examinations? _____
How often do you brush your teeth? _____
How often do you floss? _____
Are you experiencing any problems now? If yes, please explain: _____
_____
Are any of your teeth sensitive to: (circle all that apply)
Hot Temperatures Cold Temperatures Sweets Biting or Chewing

Have you noticed: **(circle all that apply)**
Mouth odors Bad taste Loose teeth Bleeding while brushing or flossing

Are you susceptible to cold sores, blisters, or other oral lesions? _____
Do your gums bleed or hurt? _____
Have you noticed a change in your bite? _____
Does food tend to get caught between your teeth? _____
If so, where? _____

Do you: (circle all that apply)
Clench or grind your teeth Bite your lips or cheeks regularly
Mouth breathe Smoke or chew tobacco Hold foreign objects in your teeth

Have you ever had: **(circle all that apply)**
Orthodontic Treatment? Periodontal Treatment? A bite guard or mouth guard? Bite Adjustment? Oral Surgery? Dental Implants? Crowns or Bridges?

Have you ever had a serious injury to the mouth or head? If so, please describe:
_____
Have you experienced: (circle all that apply)
Clicking or popping in your jaw? Pain in the jaw joint, ear, side of face?
Difficulty opening or closing the mouth? Difficulty in chewing on either side?
Headaches? Neckache? Shoulder ache? Sore muscles in neck or shoulders?

Are you satisfied with your teeth's appearance? _____
Would you like to keep your teeth all your life? _____
Are you anxious about having dental treatment? _____ If so, what is your biggest concern? _____
Have you ever had an upsetting dental experience? _____ If so, please describe:

What would you like to change about your smile? _____
_____