

Patient Name _____
Medical Alert _____

DENTAL HISTORY

Welcome! So that we may provide you with the best possible care please complete both sides of the medical/dental history form.
All information is completely confidential.

What is the reason for your visit today? _____

Do you have any dental problems now? Yes No

If yes, please describe: _____

Date of last Dental Visit _____ last Dental Cleaning _____ last Full Mouth x-rays _____

What was done at your last dental visit? _____

Did any previous dentist recommend dental treatment that was never performed? Yes No

If yes, what type of work was it? _____

Why was this treatment never performed? _____

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? (Rotodent, Interplak, toothpick, etc.) _____

Are any of your teeth sensitive to:

Hot or cold? Yes No

Sweets? Yes No

Biting or Chewing? Yes No

Noticed any mouth odors or bad tastes? Yes No

Do you frequently get cold sores, blisters or
any other oral lesion? 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
any teeth? Yes No

If yes, where? _____

Do you:

Clench/grind 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 jaws, especially in the morning? Yes No

Smoke/chew tobacco? Yes No

Do you feel nervous about dental treatment? Yes No

Ever had an upsetting dental experience? ... Yes No

If so, please describe _____

Have you ever had:

Orthodontic Treatment? Yes No

Oral Surgery? Yes No

Periodontal Treatment? Yes No

Your teeth ground or bite adjusted? Yes No

A bite plate or mouth guard? Yes No

A serious injury to the mouth or head? Yes No

If so, 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 chewing on either side of mouth? Yes No

Headaches, neck aches, or shoulder aches? Yes No

Sore muscles (neck, shoulders)? Yes No

Please **Circle** the following dental values **most important** to you
and **Underline** the **least important**:

Esthetics Comfort Longevity Function

Long-term cost effectiveness

Please **Circle** the **most important feature(s)** in your smile that
you would like to change? Color Shape Alignment

Length Gaps Gum display Nothing, I'm Happy

Other _____

Would you like your smile analyzed? Yes No

If yes, is there a spouse or significant other you want to

include in our discussion? Yes No

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

If yes, please describe _____