

Patient Name: _____

Dental History

Welcome!

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

What is the reason for your visit today? _____

Date of Last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____

What was done at your last dental visit? _____

Previous Dentist's Name _____

Address _____

Telephone _____

How often do you have dental examinations? _____

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

Have you ever used or are currently using topical fluoride? Yes No

What other dental aides do you use? (Interplak, toothpick, etc) _____

Do you have any dental problems now? Yes No

If yes, please describe: _____

Are your teeth sensitive to:

Hot or Cold? Yes No

Sweets? Yes No

Biting or Chewing? Yes No

Have you noticed any mouth odors or bad taste? Yes No

Do you frequently get cold sores, blisters or

any other oral 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 in between

your teeth? Yes No

If yes, where? _____

Have you ever had:

Orthodontic treatment? Yes No

Oral surgery? Yes No

Periodontal treatment? Yes No

Your teeth ground or the 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 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 the mouth? Yes No

Headaches, neckaches or shoulder aches? Yes No

Sore muscles (neck, shoulders)? Yes No

Have you ever been told to take a pre-medication prior to dental treatment?.....Yes No

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

If yes, please describe _____
