Patient Name	DENTAL HISTORY
Patient Account No	Medical Alert

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 _____ State _____ Zip _____
Telephone _____
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? (Interplak, toothpick, etc.) _____
Do you have any dental problems now? ☐ Yes ☐ No
If yes, please describe: _____

	Yes	No
Are any of your teeth sensitive to:		
Hot or cold?	☐	☐
Sweets?	☐	☐
Biting or Chewing?	☐	☐
Have you noticed any mouth odors or bad tastes?	☐	☐
Do you frequently get cold sores, blisters or any other oral lesions?	☐	☐
Do your gums bleed or hurt?	☐	☐
Have your parents experienced gum disease or tooth loss?	☐	☐
Have you noticed any loose teeth or change in your bite?	☐	☐
Does food tend to become caught in between your teeth?	☐	☐

If yes, where? _____

	Yes	No
Do you:		
Clench or grind your teeth while awake or asleep?	☐	☐
Bite your lips or cheeks regularly?	☐	☐
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	☐	☐
Mouth breathe while awake or asleep?	☐	☐
Have tired jaws, especially in the morning?	☐	☐
Snore or have any other sleeping disorders?	☐	☐
Smoke/chew tobacco or use other tobacco products?	☐	☐

	Yes	No
Have you ever had:		
Orthodontic treatment?	☐	☐
Oral Surgery?	☐	☐
Periodontal treatment?	☐	☐
Your teeth ground or the bite adjusted?	☐	☐
A bite plate or mouth guard?	☐	☐
A serious injury to the mouth or head?	☐	☐

If so, please describe, including _____

	Yes	No
Have you experienced:		
Clicking or popping of the jaw? Pain? Joint, ear, side of face)	☐	☐
Difficulty in opening or closing the mouth?	☐	☐
Difficulty in chewing on either side of the mouth?	☐	☐
Headaches, neckaches or shoulder aches?	☐	☐
Sore muscles (neck, shoulders)?	☐	☐
Are you satisfied with your teeth's appearance?	☐	☐
Would you like to keep all of your teeth all of your life?	☐	☐
Do you feel nervous about having dental treatment?	☐	☐
If so, what is your biggest concern?		
Have you ever had an upsetting dental experience?	☐	☐

If yes, please _____

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