DENTAL HISTORY

Patient Name	Date of Birth

What is the reason for your visit today? _____

What are your specific concerns today? _____

Previous Dentist's Name _____
Phone # _____ City _____ State _____

Date of last dental visit _____ Purpose of your last dental visit _____

Date of last dental cleaning _____ How often do you visit the dentist _____

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

What dental aids do you use: (circle all that apply)

tooth pick	floss picks	proxabrush	soft pick	power toothbrush	other

Please check ALL of the following conditions that apply

Are any of your teeth sensitive?
___ hot ___ cold ___ sweets
___ biting ___ chewing

Have you noticed any mouth odor or bad tastes?
___ yes ___ no

Do you frequently get:
___ cold sores ___ blisters ___ other oral lesions

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 ___ yes ___ no
If yes, where? _____

Does food tend to become caught in between your teeth
___ yes ___ no If yes, where? _____

Have you experienced:
___ clicking or popping of the jaw
___ any pain? ___ joint ___ear ___ side of face
___ difficulty in opening or closing the mouth
___ difficulty in chewing: ___ right side ___ left side
___ clenching or grinding: ___ while awake ___ while sleeping
___ tired jaws, especially in the morning

Do you wear any appliances during the day or night?
___ retainer ___ nightguard ___ snoring ___ sleep apnea/CPAP

Have you ever had an injury or accident to the mouth or head?
Please explain: _____
_____

Have you had orthodontic treatment _____
Do you routinely see a periodontist? _____
How often are you seen: _____
Periodontist name _____

Have your wisdom teeth been removed _____
Do you have any dental implants _____
If yes, where? ___ upper ___ lower ___right ___left

Are you satisfied with your teeth's appearance: _____

Are you interested in learning about teeth whitening options or options to improve the appearance: _____

Do you feel nervous about having dental treatment: _____ If so, what is your biggest concern:
_____

PATIENT/GUARDIAN SIGNATURE _____ **DATE** _____