

Patient Name \_\_\_\_\_  
 Patient Account No. \_\_\_\_\_

**DENTAL HISTORY**

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? \_\_\_\_\_

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

What other dental aids do you use? (Interplak, toothpick, etc.) \_\_\_\_\_

Do you have any dental problems now? Yes No

If yes, please describe: \_\_\_\_\_

**Are any of 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 tastes?                       | 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? \_\_\_\_\_

**Do you:**

- |   |     |    |
|---|-----|----|
| Clench or grind your 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 |
| Snore or have any other sleeping disorders?                                     | Yes | No |
| Smoke/chew tobacco or use other tobacco products?                               | Yes | No |

**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 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 in chewing on either side of the mouth? | Yes | No |
| Headaches, neckaches or shoulder aches?            | Yes | No |
| Sore muscles (neck, shoulders)?                    | Yes | No |

**Are you satisfied with your teeth's appearance?** Yes No  
 Would you like to keep all of your teeth all of your life? Yes No

Do you feel nervous about having dental treatment? Yes No  
 If so, what is your biggest concern? \_\_\_\_\_

Have you ever had an upsetting dental experience? Yes No  
 If yes, please describe \_\_\_\_\_

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 \_\_\_\_\_  
 \_\_\_\_\_

(Please complete other side)