

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?**

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)