## DENTAL HISTORY

**Patient Name**_______________________________________________________

**Medical Alert**_______________________________________________________

**So that we may provide you with the best possible care, please complete the 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?________________________________________

______________________________________________________________________

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_____________________________________________________

Do you require antibiotics before dental treatment? Yes_____No_____

**Are any of your teeth sensitive to:** Hot or cold? Yes___No___ Sweets? Yes___No___

Biting or chewing? Yes___No___ Do your gums bleed or hurt? Yes___No___

Do you frequently get cold sores, blisters or any other oral lesions? 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___

Do you smoke/chew tobacco? Yes___No___Mouth breathe while awake or asleep? 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___

Are you satisfied with your teeth's appearance? Yes___No___

Do you feel nervous about having dentist treatment? Yes___No___ If so, what is your biggest concern?______________________________________________________

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

______________________________________________________________________