Patient Name/Date

DENTAL HISTORY

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 ______________________________ Ph: ____________

Address ______________________________ State ________ Zip ________

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.) ______________________________

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 your food tend to become caught in between your teeth? Yes No

If yes, where? ______________________________

Have you experienced:

Clicking or popping of the jaw? Yes No

Pain? (joint, ear, side of face) Yes No

Difficulty in opening or closing 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

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

Smoke/chew tobacco? Yes No

Feel that snoring may be a problem? Yes No

Wake yourself trying to catch your breath? 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 ______________________________

____

Are you satisfied with your teeth's appearance? Yes No

Are there spaces between your teeth that you don't like? .... Yes No

If yes, please describe: ______________________________

Do you consider your teeth to be in good alignment (straight)? .... Yes No

If no, please describe: ______________________________

Do you like the color of your teeth? .... Yes No

If no, please describe: ______________________________

Do you like the shape your teeth? .... Yes No

If no, please describe: ______________________________

Do you like the way your upper and lower teeth fit together when you bite? .... Yes No

If no, please describe: ______________________________

Are there any existing fillings or dental treatment that you are unhappy with? .... Yes No

If yes, please describe: ______________________________

Do you think your gums are unattractive? .... Yes No

If yes, please describe ______________________________

What would you like to change most in the appearance of your teeth, your smile?

____

Have you ever had an upsetting dental experience? .... Yes No

If yes, please describe ______________________________

Do you feel nervous about having dental treatment? .... Yes No

If so, what is your biggest concern?______________________________