Patient Name
Medical Alert

DENTAL HISTORY

Welcome! So that we may provide you with the best possible care please complete both the dental and medical history form.
All information is completely confidential.

What is the reason for your visit today? _____

Do you have any dental problems now? Yes No
If yes, please describe:

Date of last Dental Visit Last Dental Cleaning Last Full Mouth x-rays

What was done at your last dental visit?

Did any previous dentist recommend dental treatment that was never performed? Yes No

If yes, what type of work was it?_____

Why was this treatment never performed?

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? (Rotodent, Interplak, toothpick, etc.)

Are any of your teeth sensitive to:
Hotorcold? ..... Yes No
Sweets? ..... Yes No
Biting or Chewing? ..... Yes No
Noticed any mouth odors or bad tastes? .... Yes No
Do you frequently get cold sores, blisters or any other oral lesion? ..... 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 inyourbite? ..... Yes No
Does food tend to become caught between anyteeth? ..... Yes No
If yes, where? _____

Do you:
Clench/grind 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

Do you feel nervous about dental treatment? Yes No
Ever had an upsetting dental experience? ...Yes No
If so, please describe_____

Have you ever had:
Orthodontic Treatment? ..... Yes No
Oral Surgery? ..... Yes No
Periodontal Treatment? .....Yes No
Your teeth ground or 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 chewing on either side of mouth? ..... Yes No
Headaches, neck aches, or shoulder aches? .....Yes No
Sore muscles (neck, shoulders)? ..... Yes No

Please **Circle** the following dental values **most important** to you and **Underline the least important:**
Esthetics Comfort Longevity Function
Long-term cost effectiveness

Please Circle the most important feature(s) **in your smile that you would like to change?** Color Shape Alignment
Length Gaps Gum display Nothing, I'm Happy
Other _____

Would you like your smile analyzed? ..... Yes No
If yes, is there a spouse or significant other you want to include in our discussion? ..... Yes No

Is there anything else about having dental treatment that you would like us to know?

If yes, please describe