Patient Name _____

Medical Alert _____

DENTAL HISTORY

Welcome! So that we may provide you with the best possible care please complete both sides of the medical/dental 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:

Hot or cold? …….	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 in your bite? ……	Yes	No
Does food tend to become caught between any teeth? ……..	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? Yes No
If yes, please describe _____