PATIENT NAME___________________________________

DENTAL HISTORY

WELCOME! So that we may provide you with the best possible care,
Please complete both sides of this dental and medical history form.
ALL INFORMATION IS KEPT COMPLETELY CONFIDENTIAL.

What is the reason for your visit today?_______________________________________
____

Date of last dental visit______________Last dental cleaning_____________Last dental x-rays_______________
Previous dentist's name____Telephone #_________________
Address____City________________State_______Zip________

How often do you brush your teeth?____________________How often do you floss?__________________
What other dental aids do you use? Waterpik Toothpick Listerine Fluoride rinse Other_______________
Brush is: Soft Medium Hard Do you MANUALLY brush or use ELECTRIC toothbrush?

Are any of your teeth sensitive to:

Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or chewing?	Yes	No
Have you noticed mouth odors/bad taste?	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/grind your teeth while awake/sleep?	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
Have swelling(s)/lump(s) in your mouth?	Yes	No
Have burning tongue/lips?	Yes	No

Have you ever had:

Orthodontic treatment (braces)?	Yes	No
Oral surgery?	Yes	No
Periodontal (gum) treatment?	Yes	No
Your bite adjusted (teeth 'ground down')?	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 your mouth?	Yes	No
Difficulty chewing on either side of your mouth?	Yes	No
Headaches, neck aches or shoulder aches?	Yes	No
Abnormal bleeding after previous extractions/surgery?	Yes	No
Are you satisfied with your teeth's appearance?	Yes	No
Would you like to keep all of your teeth all of your life?	Yes	No
Do your feel nervous about 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____________________________
____

ADDITIONAL CHILD INFORMATION

Does child have: Any mouth habits (thumb sucking, pacifier, bottle, grinding, etc.)?_______________
Any unusual speech habits?____

Does child brush teeth daily?.. Yes No
Is child assisted with: Tooth brushing?............................ Yes No
Flossing?.. Yes No
Is fluoride taken (rinse, tablets, etc.)?............................... Yes No

<PLEASE COMPLETE OTHER SIDE>