Dental History

Patient Name: ____________________

What is the reason for your visit today? ____________________

Date of Last Dental Visit __________ Last Dental Cleaning __________ Last X-Rays __________

Previous Dentist's Name ____________________

How often do you brush your teeth? __________ How often do you floss? __________

What other dental aids do you use? (Waterpik, toothpick, etc.) __________

Do you have any dental problems now? Yes No

Please describe: ____________________

Are you satisfied with the appearance of your teeth? Yes No

Do you feel nervous about dental treatment Yes No

If yes, what is your biggest concern? ____________________

Have you ever considered whitening your teeth? Yes No

Would you like more information on whitening? Yes No

Would you like to know if you are a good candidate for ortho? Yes No

Are any of your teeth sensitive to?

Hot or cold Yes No

Sweets Yes No

Biting or Chewing Yes No

Have you noticed any odor or bad tastes? Yes No

Do you frequently get cold sores, blisters, any other oral lesions? Yes No

Do your gums hurt or bleed? 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?

Mouth breathe while awake or asleep Yes No

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

Smoke/chew tobacco or use other products Yes No

Snore or have other sleep disorders Yes No

Have tired jaws especially in the morning Yes No

Have you ever had?

Orthodontic treatment Yes No

Oral Surgery Yes No

Periodontal treatment Yes No

Your teeth ground down or bite adjusted Yes No

A bite plate or mouth guard Yes No

A serious injury to the mouth or head Yes No

If yes, please describe __________

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Have you experienced?

Clicking or popping of the jaw Yes No

Pain in the jaw joint or ear Yes No

Difficulty in opening or closing your mouth Yes No

Difficulty in chewing on either side of your mouth Yes No

Headaches or neckaches Yes No

Sore shoulder muscles Yes No

Is there anything else about having dental treatment you would like us to know? Yes No

If yes, please describe? ____________________