Patient Name	**DENTAL HISTORY**
Patient Account No.	Medical Alert

WELCOME!! So that we may provide you with the best possible care, please complete both sides of this medical/dental history form. All information is completely confidential.

What is the reason for your visit today? _____

If you were able to change anything about your smile, what would you change? _____

Date of last Dental Visit _____ **Last Dental Cleaning** _____ **Last Full Mouth X-rays** _____
What was done at your last dental visit? _____

Previous Dentist's Nan_____ State _____ Zip _____
Address _____ Telephone (_____)_____

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? (Hydrofloss, Electric Toothbrush, Toothpick) _____

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

Please circle the correct response to:

Are any of your teeth sensitive to:			Have you had orthodontic treatment?	Yes	No
Hot or cold?	Yes	No	Have you had oral surgery?	Yes	No
Sweets?	Yes	No	Have you had periodontal treatment?	Yes	No
Biting or Chewing?	Yes	No	Have you had your bite adjusted?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No	Have you had a mouth guard or bite plate?	Yes	No
Do you frequently get cold sores, blisters or lesions?	Yes	No	Have you had a serious head or mouth injury?	Yes	No
Do your gums bleed or hurt?	Yes	No	If so, please describe, including cause:		
Have your parents experienced gum disease of tooth loss?	Yes	No	_____		
Have you noticed any loose teeth or change in your bite?	Yes	No	Have you experienced clicking or popping?	Yes	No
Does food tend to get caught between your teeth?	Yes	No	Have you experienced pain (joint, ear, face)?	Yes	No
If so, where?			Have you had difficulty chewing?	Yes	No
_____			Have you had headaches or neckaches?	Yes	No
Do you clench or grind your teeth?	Yes	No	Have you had shoulder aches or muscle aches?	Yes	No
Do you bite your lips or cheeks regularly?	Yes	No	Are you satisfied with your teeth's appearance?	Yes	No
Do you hold foreign objects in your teeth?	Yes	No	Would you like to keep your teeth for life?	Yes	No
Do you bite your nails?	Yes	No	Do you feel nervous about dental treatment?	Yes	No
Do you mouth breathe while awake or asleep?	Yes	No	If so, what is your biggest concern?		
Do you smoke or chew tobacco?	Yes	No	_____		
			Have you ever had an upsetting dental experience?	Yes	No
			If so, please describe:		
			_____		

Is there anything else about having dental treatment that you would like us to know about? Yes No
If yes, please describe: _____

(Please complete the other side)