Dental Professionals

Dental History

Patient Name

Date

Welcome! Please complete both sides of this dental/medical history form so that we may provide you with the best possible dental care.

All information is completely confidential.

What is the reason for your visit today? _____

_____

Date of Last Dental Visit?_____Last Dental Cleaning_____Last Full Mouth X-rays _____

What was done at your last dental visit? _____

Previous Dentist's Name_____Telephone _____

Address_____State_____Zip_____

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 (Sonicare, waterpick, etc.)? _____

Do you have any dental problems now? Yes | No

If yes, please describe: _____

Are any of your teeth sensitive to any of the following?

Hot or cold?	Yes | No
Sweets?	Yes | No
Biting or chewing?	Yes | No
Bad taste/ mouth odor?	Yes | No
Do you get frequent cold sores?	Yes | No
Bleeding gums?	Yes | No
Food collection between teeth?	Yes | No
Do your gums hurt?	Yes | No

Have you ever had?

Orthodontic Treatment?	Yes | No
Are you interested in orthodontic treatment?	Yes | No
Periodontal Treatments?	Yes | No
A nightguard?	Yes | No
Oral Surgery?	Yes | No
Root Canal Therapy?	Yes | No
Whitening?	Yes | No
Implant Treatment?	Yes | No

Do you:

Clench or grind your teeth?	Yes | No
Bite your lips or cheeks regularly?	Yes | No
Mouth breathe?	Yes | No
Snore?	Yes | No
Smoke/ chew tobacco?	Yes | No

Have you experienced?

Clicking or popping of the jaw?	Yes | No
Pain in ear, side of face, jaw joint?	Yes | No
Difficulty opening or closing mouth?	Yes | No
Frequent headaches?	Yes | No
Difficulty chewing on either side of mouth?	Yes | No

Do you have any other dental conditions not listed? Yes | No If yes, what? _____

Are you nervous coming to the dentist or having dental treatments? Yes | No

Is there anything you'd like to discuss with the dentist? Yes | No If yes, what? _____

Have you ever been told to take a pre-medication prior to dental treatment? Yes | No