

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 \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_