

# DENTAL HISTORY

<b>Patient Name</b>
<b>Patient Account No.</b>

<b>Medical Alert</b>
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Please complete form. All information is confidential.

What is the reason for your visit today? \_\_\_\_\_

\_\_\_\_\_

Date of Last Dental Visit \_\_\_\_\_ Last Dental Cleaning \_\_\_\_\_ Last Full Month X-rays \_\_\_\_\_

\_\_\_\_\_

Previous Dentist's Name \_\_\_\_\_

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? (Interplak, toothpick, etc) \_\_\_\_\_

Do you have any dental problems now? Yes No

If yes, please describe: \_\_\_\_\_

**Are any of your teeth sensitive to:**

Hot or Cold? Yes No

Sweets? Yes No

Biting or Chewing? Yes No

Have you noticed any mouth odors or bad tastes? Yes No

Do you frequently get cold sores, blisters or any 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 in your bite? Yes No

Does food tend to become caught in between your teeth? Yes No

If yes where? \_\_\_\_\_

**Do you:**

Clench or grind your teeth while awake or asleep? Yes No

Bite your lip or cheeks regularly? Yes No

Shoulder aches? Yes No

Hold foreign objects with your teeth? (pencils, pipes, pins, nails) Yes No

Mouth breathe while you are awake or sleep? Yes No

Have tired jaws, especially in the morning? Yes No

Smoke/Chew Tobacco Yes No

Is there anything else about having dental treatment that you would like us to know? If yes, please describe \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Have you ever had:**

Orthodontic Treatment? Yes No

Oral Surgery? Yes No

Periodontal treatment? Yes No

Your teeth ground or the bite adjusted? Yes No

A serious injury to the mouth or head? Yes No

If so please describe \_\_\_\_\_

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