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.

DENTAL HISTORY

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 ____________________ Phone ____________________

Address ____________________ City ________ State ________ Zip ________

How often do you have dental exams? ____________________

Do you regularly eat or drink (other than water) between meals? ____________________

Does your diet contain a significant amount of sugary liquids___ snack food or junk food_______

Do you frequently use cough drops___ breath mints___ hard candy___ chewing gum___ tobacco___ soft drinks___ antacids___

Place a "B" beside the times of day you usually brush and an "F" beside the times of day you usually floss.

___Upon Waking before Breakfast ___After Breakfast ___After Lunch ___After Supper ___Just before bedtime ___Other

Normally, how often do you floss?_________

Do you use: toothpicks_______ water pick_______ electric toothbrush_______ other aids_______

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 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 in between your teeth? Yes No

If yes, Where? ____________________

Do You:

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

Mouth breathe while awake or asleep? Yes No

Have tired jaws, especially in the morning? Yes No

Smoke/chew tobacco? Yes No

Are you safisfied with your teeth's appearance? Yes No

Would you like to keep all of your teeth all of your life? Yes No

Do you or your spouse have a problem with snoring? Yes No

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 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 in chewing on either side of the mouth? Yes No

Headaches, neckaches or shoulder aches? Yes No

Sore muscles (neck, shoulders)? Yes No

Do you feel nervous about having dental treatment? Yes No

If so, what is your biggest concern? ____________________

____

Have you ever had an upsetting dental experience? Yes No

If yes, please describe ____________________

____

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

If yes, please describe ____________________

____

____

(Please complete the other side)

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