

### Dental History

Patient First Name:

Patient Last Name:

Home Phone:

Reason for your visit?

Previous Dentist's Name:

Previous Dentist's Address:

**How often do you...**

**What was the date of your last...**

brush your teeth?

visit?

floss your teeth?

hygiene visit?

have dental exams?

X-Ray's?

What other aids do you use (electric toothbrush, tooth pick, etc.)?

Do you have any dental problems at this time? ☐ Yes ☐ No

If yes, explain:

#### **Personal History**

YES NO

1. Have you ever had orthodontic treatment (braces)?

☐ ☐

2. Have you ever had oral surgery?

☐ ☐

3. Have you ever had any teeth removed?

☐ ☐

If so, have they been replaced? ☐ Yes ☐ No

4. Have you ever had a fixed bridge?

☐ ☐

5. Have you ever had a removable partial?

☐ ☐

6. Have you ever had a complete denture?

☐ ☐

7. Have you ever had an implants?

☐ ☐

If so, are you happy with the replacements?

☐ ☐

8. Have you ever had periodontal treatment?

☐ ☐

9. Have you ever had gum surgery?

☐ ☐

If so, when?

by whom?

10. Have you ever had your teeth ground or bite adjusted?

☐ ☐

10. Have you ever had your teeth ground or bite adjusted? ☐ ☐

11. Have you ever had a serious injury to the mouth or head? ☐ ☐

If so, please describe (include cause):

12. Do you feel anxiety about having dental treatment? ☐ ☐

How did you overcome your anxiety?

13. Have you ever had an upsetting dental experience? ☐ ☐

If yes, please describe:

**Appearance**

1. Do you like the appearance of your teeth and smile? ☐ ☐

2. Do you like the color of your teeth? ☐ ☐

3. Would you like your teeth straightened? ☐ ☐

4. What would you like to change most in the appearance of your teeth?

**Tooth Structure**

1. Are any of your teeth sensitive to hot or cold liquids/foods? ☐ ☐

2. Are any of your teeth sensitive to sweet or sour liquids/foods? ☐ ☐

3. Are any of your teeth sensitive to biting or pressure? ☐ ☐

4. Have you noticed any loose teeth or change in your bite? ☐ ☐

5. Do you get food caught between your teeth? ☐ ☐

**Gum and Bone**

1. Have you ever noticed any mouth odors or bad taste? ☐ ☐

2. Do you frequently get cold sores, blisters, or any lesions? ☐ ☐

3. Do your gums bleed or hurt? ☐ ☐

4. Have your parents experienced gum disease or tooth loss? ☐ ☐

**Bite and Jaw Joint**

- |  |                       |                       |
|--|-----------------------|-----------------------|
| 3. Do you bite your lips or cheeks regularly?  | <input type="radio"/> | <input type="radio"/> |
| 4. Do you hold foreign objects with your teeth (pencils, pens, nails, fingernails, pipe)?          | <input type="radio"/> | <input type="radio"/> |
| 5. Do you mouth breathe while asleep or awake?   | <input type="radio"/> | <input type="radio"/> |
| 6. Do you snore?   | <input type="radio"/> | <input type="radio"/> |
| 7. Have you ever experienced clicking or popping of the jaw?                                       | <input type="radio"/> | <input type="radio"/> |
| 8. Have you ever experienced pain (joint, ear or side of face)?                                    | <input type="radio"/> | <input type="radio"/> |
| 9. Have you ever experienced difficulty opening or closing the mouth?                              | <input type="radio"/> | <input type="radio"/> |
| 10. Have you every experienced frequent headaches, neck aches, or shoulder aches?                  | <input type="radio"/> | <input type="radio"/> |
| 11. Have you ever experienced any pain or soreness in the muscles of your face or around the ears? | <input type="radio"/> | <input type="radio"/> |

Is there anything else about having dental treatment that you would like to let us know?

I consent to the doctor's exam and necessary diagnostics for treatment including x-rays.

X \_\_\_\_\_