

# DENTAL HISTORY FORM

Name \_\_\_\_\_ Date \_\_\_\_\_

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

Previous dentist's name	_____	How often do you have dental exams?	_____
Date of last visit	_____	How often do you brush your teeth?	_____
Date of last cleaning	_____	How often do you floss your teeth?	_____
Date of last full mouth x-rays	_____	What dental aids do you use?	_____

Are you satisfied with the appearance of your teeth?	yes	no	Have your teeth been ground or bite adjusted?	yes	no
Would you like to keep all of your teeth?	yes	no	Do you wear a bite plate or mouth guard?	yes	no
Are your teeth sensitive to hot?	yes	no	Have you had a serious injury to head or mouth?	yes	no
Are your teeth sensitive to cold?	yes	no	Have you noticed popping of the jaw?	yes	no
Have you ever had Orthodontic treatment?	yes	no	Have you noticed a change in your bite?	yes	no
Have you ever had Periodontal treatment?	yes	no	Have you experienced clicking or joint pain?	yes	no
Do your gums bleed or hurt?	yes	no	Any difficulty in opening or closing your mouth?	yes	no
Have your parents experienced gum disease?	yes	no	Do you clench or grind your teeth?	yes	no
Have you noticed loose teeth?	yes	no	Do you have head, neck, shoulder pain?	yes	no
Does food become caught between your teeth?	yes	no	Are you nervous about dental treatment?	yes	no
Do you mouth breath while awake or asleep?	yes	no	Have you ever had an upsetting dental experience?	yes	no
Do you smoke or chew tobacco?	yes	no	Do you get cold sores or other lesions?	yes	no

Please describe anything about your past or future dental treatment that you would like to have us know.

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

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Dentist Signature \_\_\_\_\_ Date \_\_\_\_\_