DENTAL HISTORY

Patient Name_____ Date____/____/_____

So that we may understand your dental needs and concerns better, please complete this dental history form.

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 _____City _____State_____

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 _____
_____

Have your parents experienced gum disease or tooth loss? ❑Yes ❑No
Have you noticed any loose teeth or changes in your bite? ❑Yes ❑No
Does food tend to become caught in between your teeth? ❑Yes ❑No

Do you clench or grind your teeth while awake or asleep? ❑Yes ❑No
Do you wake up with: ❑ Tired jaws ❑ Headaches
Have you experienced: ❑Clicking or popping of the jaw ❑ Pain in your jaw joints, ear, or face
❑ Difficulty in opening or closing ❑Difficulty in chewing ❑Frequent headaches ❑Sore muscles?
Have you ever: ❑Been treated for TMJ ❑Had your bite adjusted ❑Worn a bite splint or night guard?

Have you ever had: ❑Orthodontic treatment ❑Oral Surgery ❑Periodontal treatment?
Do you use tobacco? ❑Cigarettes ❑Smokeless
What would you like to do to improve your smile? ❑Whiten teeth ❑Straighten teeth ❑Close spaces?
Have you ever had local anesthetic (Novocain) for dental purposes? ❑Yes ❑No
Have you ever had Nitrous Oxide (laughing gas)? ❑Yes ❑No
Have you ever had any negative reactions to a dental injection or nitrous oxide? ❑Yes ❑No
Please describe_____

Do you feel nervous about having dental treatment? ❑Yes ❑No
If so, what is you biggest concern? _____
Is there anything else about having dental treatment that you would like us to know?
Please explain _____
_____
_____
_____