DENTAL HISTORY

Patient Name ______________________ Date of Birth ______________

What is the reason for your visit today? ______________________

Date of Last Dental Visit ____________ Last Dental Cleaning ____________ Last Dental X-rays __________

Previous Dentist Name and Phone Number ______________________

How often do you brush your teeth? ______________ How often do you floss? ______________

What other dental aids do you use (toothpick, waterpik, etc.) ______________________

Do you currently have any dental problems? ☐ Yes ☐ No

If yes, please explain: ______________________

Are any of your teeth sensitive to:

YES NO
- ☐ ☐ Hot or Cold
- ☐ ☐ Sweets
- ☐ ☐ Biting or Chewing
- ☐ ☐ Any mouth odors or bad tastes?

YES NO
- ☐ ☐ Do you get cold sores, blisters, or any other oral lesions frequently?
- ☐ ☐ Do your gums bleed or hurt?
- ☐ ☐ Any loose teeth or changes in your bite?
- ☐ ☐ Does food get caught in between your teeth?

Do you:

YES NO
- ☐ ☐ Clench or grind your teeth?
- ☐ ☐ Bite your lips or cheeks regularly?
- ☐ ☐ Bite on foreign objects with your teeth? (ie: Pencils/pens/pipe/fingernails)

YES NO
- ☐ ☐ Have soreness in your jaw?
- ☐ ☐ Snore or have any sleep disorders?

Is there anything you would like us to know about your dental care or treatment? ______________________

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If there were anything you could change about your smile, what would it be? ______________________

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To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. I will notify the dental office of any changes in my dental health status.

Signature of Patient, Parent or Guardian ______________________ Date ______________

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