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Cosmetic & Family Dentistry

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DENTAL HISTORY

Patient's Name _____ Person Completing Form _____
Medical Alert _____

What's the reason for your visit today? _____
_____

Date of last dental visit _____ Last dental cleaning _____ Last full mouth of x-rays _____
What was done at your last dental visit? _____
_____

Previous dentist's name _____ Address _____ Phone # _____
How often do you have dental examinations? _____
How often do you brush your teeth? _____ How often do you floss? _____
Have you ever used or are you currently using topical fluoride? ☐Yes ☐No
What are other dental aids do you use? Example: Electric toothbrush, Waterpick, etc. _____
Do you have any dental problems now ☐Yes ☐No
If yes, please specify _____
_____

Please answer the following:

Sensitivity to hot or cold? ..... ☐Yes ☐No
Sensitivity to sweets?..... ☐Yes ☐No
Sensitivity to biting or chewing? ..... ☐Yes ☐No
Have you noticed any mouth odors or bad taste? ..... ☐Yes ☐No
Do you frequently get cold sores, blisters or any other lesions? ☐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 get caught in between your teeth?..... ☐Yes ☐No
If yes where _____
_____
_____

Do you:

Clench or grind your teeth while you're awake or sleeping? ☐Yes ☐No
Bite your lips or cheeks regularly? ..... ☐Yes ☐No
Hold foreign objects with your teeth? ..... ☐Yes ☐No
(Pencils, pipes, pins, nails, fingernails?)
Mouth breathe while awake or asleep? ..... ☐Yes ☐No
Have tired jaws, especially in the morning? ..... ☐Yes ☐No
Snore or have any sleep disorders? ..... ☐Yes ☐No
Smoke/Chew tobacco, vape, smoke marijuana? ..... ☐Yes ☐No
Do you regularly drink soda, energy or sport drinks? ..... ☐Yes ☐No

Have you ever had:

Orthodontic Treatment..... ☐Yes ☐No
Oral Surgery ..... ☐Yes ☐No
Periodontal Treatment ..... ☐Yes ☐No
Your teeth ground on or adjusted ..... ☐Yes ☐No
A bite plate or mouth guard..... ☐Yes ☐No
A serious injury to the mouth or head ☐Yes ☐No
If yes, please describe _____
_____

Have you experienced:

Clicking or popping of the jaw?..... ☐Yes ☐No
Pain? (Joint, ear, side of face) ..... ☐Yes ☐No
Difficulty opening or closing mouth..... ☐Yes ☐No
Difficulty chewing..... ☐Yes ☐No
Headaches, neck, shoulder aches..... ☐Yes ☐No
Sore muscles (neck, shoulder)..... ☐Yes ☐No

Are you satisfied with your teeth's appearance?

Do you feel nervous about dental treatment? ☐Yes ☐No
If so, what is your biggest concern?
_____
Have you ever had an upsetting dental experience?
If so, what is your biggest concern?
_____

Have you ever been told to take a pre-medication prior to dental treatment? ☐Yes ☐No
Is there anything else about having dental treatment done that would like us to know? ☐Yes ☐No
If yes, please describe_____
_____

Dr/Employee Notes:

I understand the above information is necessary to provide me with the dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature _____ Date _____