



Patient Name
Patient Account No.

# DENTAL HISTORY

Medical Alert
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*Welcome! So that we may provide you with the best possible care,  
please complete both sides of this medical/dental history form.  
All information is completely confidential.*

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 \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Address \_\_\_\_\_  
Telephone \_\_\_\_\_

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: \_\_\_\_\_

**Are any of your teeth sensitive to:**  
Hot or Cold? Yes No  
Sweets? Yes No  
Biting or Chewing? Yes No  
Have you noticed any mouth odors or bad tastes? Yes No  
Do you frequently get cold sores, blisters or  
any other oral lesions? Yes No

**Do your gums bleed or hurt?**  
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 become caught in between  
your teeth? Yes No  
If yes, where? \_\_\_\_\_

**Do you:**  
Clench or grind your teeth while awake or asleep? Yes No  
Bite your lips or cheeks regularly? Yes No  
Hold foreign objects with your teeth?  
(pencils, pipe, pins, nails, fingernails) Yes No  
Mouth breathe while awake or asleep? Yes No  
Have tired jaws, especially in the morning? Yes No  
Smoke/chew tobacco? Yes No

**Have you ever had:**  
Orthodontic treatment? Yes No  
Oral surgery? Yes No  
Periodontal treatment? Yes No  
Your teeth ground or the bite adjusted? Yes No  
A bite plate or mouth guard? Yes No  
A serious injury to the mouth or head? Yes No  
If so, please describe, including cause \_\_\_\_\_  
\_\_\_\_\_

**Have you experienced:**  
Clicking or popping of the jaw? Yes No  
Pain? (joint, ear, side of face) Yes No  
Difficulty in opening or closing the mouth? Yes No  
Difficulty in chewing on either side of the mouth? Yes No  
Headaches, neckaches or shoulder aches? Yes No  
Sore muscles (neck, shoulders)? Yes No

**Are you satisfied with your teeth's appearance?** Yes No  
Would you like to keep all of your teeth all of your life? Yes No  
Do you feel nervous about having dental treatment? Yes No  
If so, what is your biggest concern?  
\_\_\_\_\_  
Have you ever had an upsetting dental experience? Yes No  
If yes, please describe \_\_\_\_\_  
\_\_\_\_\_

Is there anything else about having dental treatment that you would like us to know? Yes No  
If yes, please describe \_\_\_\_\_  
\_\_\_\_\_