DENTAL HISTORY

Welcome! So that we may provide you with the best possible care, please complete this medical history form. All information is completely confidential.

Patient Name: _____ Date: _____

What is the reason for your visit today? _____

_____

Date of last dental visit_____ When was your last dental cleaning?_____

Previous Dentists Name & Address: _____

How often do you: Have dental cleanings? _____ Brush your teeth?_____ Floss?_____

What type of toothbrush do you use (circle those applicable)?.....Manual / Electric

If you use a manual toothbrush, what type of brush do you use?.....Soft / Medium / Hard

If you use an electric toothbrush, what brand do you use? _____

Do you use a tartar control or whitening toothpaste?.....Yes / No

Are any of your teeth sensitive to (please circle): Sweets Hot Cold Biting Chewing None

Do you:

Clench or grind your teeth?.....Yes / No

Have tired jaws, especially in the morning?.....Yes / No

Have you ever had:

Orthodontic treatment (braces, appliances, expanders, etc)?.....Yes / No

Oral Surgery?.....Yes / No

Periodontal Treatment (surgery, scaling and root planning or "deep cleanings")? .....Yes / No

A night guard, splint, or mouthguard? .....Yes / No

Any injury to the mouth, jaw, or head? ……..Yes / No

If yes, please explain_____

Have you experienced:_

Clicking or popping of the jaw?.....Yes / No

Pain (joint, ear, side of face)? .....Yes / No

Difficulty in chewing on either side of the mouth? .....Yes / No

Difficulty in opening or closing your mouth? .....Yes / No

Do you frequently get cold sores, canker sores, blisters or any other oral lesions?.....Yes / No

Have you ever had your teeth professionally whitened?.....Yes / No

If yes, when?_____

Are you interested in learning about how whitening can improve your smile?.....Yes / No

Are you satisfied with the appearance of your teeth? .....Yes / No

Is there anything you would change about your smile? .....Yes / No

If yes, please explain_____

Is it important to you to keep all of your teeth for the rest of your life? .....Yes / No

On a scale of #1-10 (#1 being the least important, #10 being the most) how important is your dental health?....._____

Do you feel nervous about having dental treatment? .....Yes / No

If yes, what is your biggest concern?_____

_____

Have you ever had an upsetting dental experience? .....Yes / No

If yes, please explain_____

_____

Is there anything else about having dental treatment that you would like us to know?.....Yes / No

If yes, please explain_____

_____

Patient/Guardian Signature_____ OVER →