PATIENT DENTAL HISTORY

So that we may provide you with the best possible care, we must first have a baseline of your current dental health. This will help to identify specific dental concerns or health conditions that may affect our treatment decisions. Please be sure to answer every question on this form.

PATIENT NAME: _____ Phone#: _____
(First) (Middle) (Last)

What is the primary reason or concern that made you think of calling us? _____
Is there something in particular that you would like us to focus on for you? _____

PLEASE PROVIDE US WITH THE FOLLOWING IMPORTANT DATES (IF POSSIBLE):

Date of Last Dental Visit: _____ What did you have done? _____ _____	Last x-rays taken: Bitewings: _____ Full mouth series: _____ Panographic (full smile): _____
Last Dental ñCleaningò: _____ - OR - Last periodontal treatment: _____	
How often do you have dental examinations? _____	How often do you brush your teeth?: _____
How often do you floss? _____ If not often, or not at all, why? _____	What other types of dental aids do you use? (Electric toothbrush, toothpick, etc.) _____
○ Are you currently in the middle of dental treatment? **YES** **NO** If ñYesò, what? _____	
○ Is there anything in particular that you would like to have done during the next 3 years? _____	

Please provide your previous dentist's name, address & phone #, so that we may contact that office if need arises:

_____
(Name) **(Address)** **(Phone)**

ARE ANY OF YOUR TEETH SENSITIVE TO:			**HAVE YOU EVER HAD:**		
Hot or cold?	Yes	No	○ Orthodontic treatment?	Yes	No
Sweets?	Yes	No	○ Oral Surgery?	Yes	No
○ Biting or Chewing?	Yes	No	Periodontal treatment?	Yes	No
ARE YOU BOTHERED BY:			○ Your teeth ground or bite adjusted?	Yes	No
Frequent cold sores, blisters or any other oral lesions?	Yes	No	○ A bite plate or mouth guard?	Yes	No
○ Any mouth odors or bad tastes?	Yes	No	○ A serious injury to the mouth or head? If ñyesò, please provide details: _____	Yes	No
Loose or clicking partial, bridge or denture?	Yes	No			
Do your gums bleed or hurt?	Yes	No	**HAVE YOU EVER EXPERIENCED:**		
Have your parents experienced gum disease or tooth loss?	Yes	No	○ Clicking or popping of the jaw?	Yes	No
○ Have you noticed any loose teeth?	Yes	No	○ Pain? (joint, ear, side of face)	Yes	No
○ Have you noticed any change in how your teeth fit together?	Yes	No	○ Difficulty opening or closing your mouth?	Yes	No
Does food tend to get caught between your teeth? If ñyesò, where? _____ _____	Yes	No	○ Difficulty chewing on either side of your mouth?	Yes	No
			○ Headaches, neck aches or shoulder aches?	Yes	No
			○ Sore muscles (neck, shoulders)?	Yes	No
DO YOU:			**ARE YOU SATISFIED WITH HOW YOUR TEETH LOOK and/or FUNCTION?**	Yes	No
○ Clench or grind your teeth while awake or asleep?	Yes	No	Would you like to keep all of your teeth all of your life?	Yes	No
○ Bite your lips or cheeks regularly?	Yes	No	Do you feel nervous about having dental treatment? If ñyesò, what are your biggest concerns? _____ _____	Yes	No
Hold foreign objects with your teeth? (pencils, pins, paperclips, pipe, etc.)	Yes	No			
○ Breathe through your mouth while awake or asleep?	Yes	No	Have you ever had an upsetting experience at a dental office? If ñyesò, please describe: _____ _____	Yes	No
○ Have tired jaws, especially in the morning?	Yes	No			
○ Snore or have any other sleeping disorders?	Yes	No			
○ Smoke/chew tobacco or use other tobacco products?	Yes	No	Are you the type of patient who feels more comfortable having the doctor or dental assistant tell you about what is being done during your treatment?	Yes	No