

## DENTAL INFORMATION

What is the reason for your visit today? \_\_\_\_\_

Date of your last dental visit? \_\_\_\_\_ Last cleaning? \_\_\_\_\_ Last Full Mouth x-rays? \_\_\_\_\_

What was done at your last dental visit? \_\_\_\_\_

Previous Dentist's name \_\_\_\_\_

How often do you have dental visits? \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

Have you ever used or are you currently using a topical fluoride? \_\_\_\_\_

Do you have any dental problems or pain now? \_\_\_\_\_

### DENTAL HEALTH HISTORY

Are your teeth sensitive to the following?

Hot or Cold? Yes No

Sweets? Yes No

Biting or Chewing? Yes No

Do you have bad taste or mouth odors?

Yes No

Do you frequently get cold sores, blisters or other mouth 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? Yes No

Bite your lips or cheeks regularly? Yes No

Have tired jaws, especially in the morning? Yes No

Mouth Breath while asleep or awake? Yes No

Snore or have sleep disorders? Yes No

Smoke or Chew tobacco? Yes No

If yes how much? \_\_\_\_\_

Have you ever been told to Pre-Medicate Prior to dental treatment? Yes No

Have you ever had:

- ☐ Orthodontic Treatment?
- ☐ Oral Surgery?
- ☐ Periodontal Treatment?
- ☐ Your teeth ground or bite adjusted?
- ☐ A bite plate or mouth guard?
- ☐ A serious mouth or head injury?

If so please describe \_\_\_\_\_

Have you experienced any of the following?

- ☐ Clicking or popping of the jaw?
- ☐ Pain ?(joint, ear, side of face)
- ☐ Difficulty in opening/closing mouth?
- ☐ Difficulty in chewing?
- ☐ Headaches, neckaches, shoulder aches?
- ☐ Sore Muscles? (neck, shoulders)

Are you satisfied with your teeth's appearance? Yes No

Do you feel nervous about having dental treatment? Yes No

If so, what is your biggest concern? \_\_\_\_\_

Is there anything else about having dental treatment that you would like us to know? \_\_\_\_\_

Signature of patient (or parent) \_\_\_\_\_ Date \_\_\_\_\_