

DENTAL HISTORY FORM

Welcome!

So we may provide you with the utmost care, please complete both sides of the Medical and Dental History Forms.

Title: _____ **First:** _____ **MI** _____ **Last:** _____ **Nickname:** _____

Today's Date: _____ **Date of Last Dental Visit:** _____ **Date of Birth:** _____

	<u>Yes</u>	<u>No</u>	<u>Unknown</u>	<u>Comments</u>
Are you having pain in your mouth now?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do your gums bleed? When?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you been told you have periodontal pocketing or disease?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you concerned about staining or tartar buildup?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you have a unpleasant taste in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you concerned about the odor of your breath?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are any of your teeth chipped?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever had a cavity requiring a filling?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you experience frequent cavities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you aware of any rough, high or uncomfortable teeth or fillings? .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Does food catch between your teeth? Where?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever had an inlay, onlay, or crown?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever had root canal treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever had dental implants?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you had any teeth removed and not replaced?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Were you born missing any adult teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are your teeth sensitive? Hot, cold, sweets?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you have any trouble chewing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Can you chew on both sides of your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do your teeth feel even when you close your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you have pain or clicking when you open or close your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you been told you clench or grind your teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you been told you have TMJ problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you have any particular mouth habits (e.g. lip, cheek or tongue biting, pen chewing, lemon sucking)?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you wear or use any dental appliance, retainer, night guard, etc?...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you aware of loose, sore or shifting teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you currently or have you ever undergone orthodontic treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever had any facial cosmetic surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you have problems with dry mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are they due to medications or autoimmune disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever smoked or used chewing tobacco? How much?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you experience frequent "gum boils," cold sores, canker sores?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you have any oral lesions or swellings that concern you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Do you have any specific concerns or questions about your teeth? _____

Are you satisfied with the appearance of your teeth & smile?..... _____
 Would you like a Smile Evaluation? (Please complete separate form) _____

Please let us know if you have any concerns that we have not asked about. _____

Is there anything we can do to help make your visits with us more comfortable? _____

Patient / Guardian Signature: _____ **Relationship:** _____ **Date:** _____