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:**_____

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

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:**_____