Dental History

Name:	Birth Date:

Please complete both sides of this Medical / Dental History form. All information is completely confidential.

What is the reason for your visit today? _____
Previous Dentist? _____
Dentist Name Address Phone
Date of last dental visit _____ and what was done? _____
Last dental cleaning _____and full mouth X-rays? _____
How often do you have dental examinations? ☐ Every 6 months ☐ Once a year ☐ Other
Do you require antibiotics before dental treatment? ☐ Yes ☐ No
If yes, please explain what medication and why: _____
Are you currently in Pain? ☐ Yes ☐ No
If yes, please explain: _____

Are your teeth sensitive to:
- Hot
- Cold
- Sweets
- Biting or Chewing

Have you noticed:
- Mouth Odor
- Bad taste
- Bleeding gums
- Food catching between teeth
- Any loose teeth

Do you:
- Clench or Grind your teeth
- Bite your lip or cheek
- Hold foreign objects between your teeth (pens, pipe, or finger nails)
- Mouth breather while asleep or awake
- Smoke / chew tobacco

Have you ever been treated for:
- Orthodontics
- Oral Surgery
- Periodontal (Gum disease)
- Bite plate or Mouth guard
- Temporal Mandibular Joint

Have you experienced:
- Pain (jaw, ear, or side of face)
- Head aches, neck, shoulder aches or consistent sore muscle. If yes, please explain_____
  _____

Have you experienced:
- Difficulty opening or closing your mouth
- A serious injury to the mouth or head
- Clicking or popping of the jaw

How often do you brush your teeth?_____Floss?_____
Your current dental health is? ☐ Good ☐ Fair ☐ Poor
Do you,
Like your smile? ☐ Yes ☐ No
Want to keep all of your teeth? ☐ Yes ☐ No
Like the appearance of your teeth? ☐ Yes ☐ No
Want your teeth to be whiter? ☐ Yes ☐ No

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: _____

I understand that the information provided in this document is true and correct to the best of my knowledge. I also understand that the information provided herein will be held in the strictest of confidence in accordance with HIPAA compliance. It is my responsibility to notify this office of any changes in my Medical or Dental status.

_____ Date: _____
Signature of patient, parent or guardian