

Patient Name _____

Patient Account. No. _____

Medical Alert _____

Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.

What is the reason for your visit today? _____

Date of Last Dental Visit _____ **Last Dental Cleaning** _____ **Last X-rays** _____

What was done at your last dental visit? _____

Previous Dentist's Name _____

Address _____ State _____ Zip _____

Telephone _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? Yes No

If yes, please describe _____

	Yes	No
Are any of your teeth sensitive:	<input type="checkbox"/>	<input type="checkbox"/>
Hot or Cold?	<input type="checkbox"/>	<input type="checkbox"/>
Sw eets?	<input type="checkbox"/>	<input type="checkbox"/>
Biting or Chewing?	<input type="checkbox"/>	<input type="checkbox"/>
Have you noticed any mouth odors or bad tastes?	<input type="checkbox"/>	<input type="checkbox"/>
Do you frequently get cold sores, blisters or any other oral lesions?	<input type="checkbox"/>	<input type="checkbox"/>

Do your gums bleed or hurt?	<input type="checkbox"/>	<input type="checkbox"/>
Have your parents experienced gum disease or tooth loss?	<input type="checkbox"/>	<input type="checkbox"/>
Have you noticed any loose teeth or change in your bite?	<input type="checkbox"/>	<input type="checkbox"/>
Does food tend to become caught in between your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, where? _____		

Do you:	Yes	No
Clench or grind your teeth while awake or sleep?	<input type="checkbox"/>	<input type="checkbox"/>
Bite your lips or cheeks regularly?	<input type="checkbox"/>	<input type="checkbox"/>
Hold foreign objects in your teeth? (pencils, pipe, pins, nails, fingernails)	<input type="checkbox"/>	<input type="checkbox"/>
Mouth breathe while awake or asleep?	<input type="checkbox"/>	<input type="checkbox"/>
Have tired jaws, especially in the morning?	<input type="checkbox"/>	<input type="checkbox"/>
Smok e/chew tobacco	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
Have you ever had:	<input type="checkbox"/>	<input type="checkbox"/>
Orthodontic treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Oral surgery?	<input type="checkbox"/>	<input type="checkbox"/>
Periodontal treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Your teeth ground or the bite adjusted?	<input type="checkbox"/>	<input type="checkbox"/>
A bite plate or mouth guard?	<input type="checkbox"/>	<input type="checkbox"/>
A serious injury to the mouth or head?	<input type="checkbox"/>	<input type="checkbox"/>
If so, please describe, including cause _____		

Have you experienced?	<input type="checkbox"/>	<input type="checkbox"/>
Clicking or popping of the jaw?	<input type="checkbox"/>	<input type="checkbox"/>
Pain? (joint, ear, side of face)	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in opening or closing the mouth?	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in chewing on either side of the mouth?	<input type="checkbox"/>	<input type="checkbox"/>
Headaches, neckaches or shoulder aches?	<input type="checkbox"/>	<input type="checkbox"/>
Sore muscles (neck, shoulders)?	<input type="checkbox"/>	<input type="checkbox"/>

Are you satisfied with your teeth's appearance?	<input type="checkbox"/>	<input type="checkbox"/>
Would you like to keep all of your teeth all of your life?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel nervous about having dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>
If so, what is your biggest concern? _____		
Have you ever had an upsetting dental experience?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please describe _____		

Is there anything else about having dental treatment that you would like us to know?
If yes, please describe _____

