

**Patient Name:** \_\_\_\_\_

**DENTAL HISTORY**

Reason for your visit today: \_\_\_\_\_

Date of last dental visit \_\_\_\_\_ last dental cleaning \_\_\_\_\_ Last full mouth X-rays \_\_\_\_\_

Reason for your last dental visit \_\_\_\_\_ previous dentist's name \_\_\_\_\_

City/State \_\_\_\_\_ Telephone \_\_\_\_\_

**Do you brush your teeth?**  Yes  No

**How Often?** \_\_\_\_\_

**Do you floss?**  Yes  No

**does your gum bleed when you are flossing?**  Yes  No

**Do you have pain or sensitivity to:**

HOT or COLD?  Yes  No

SWEET?  Yes  No

BITING OR CHEWING?  Yes  No

**Do you frequently have?** Cold Sore  Yes  No

Burning sensation on tongue  Yes  No

Dry Mouth  Yes  No

Have your parents experience gum disease or tooth loss?  Yes  No

Have you noticed any mouth odor or bad tastes?  Yes  No Do your gums bleed or hurt?  Yes  No

Does food gets caught in between your teeth?  Yes  No Any change in your bite?  Yes  No

**Do you: (Please circle Yes or No)**

Clench or Grind your teeth?	Yes	No
Bite your lip or cheeks regularly?	Yes	No
Bite on Fingernails, pencil, or etc.?	Yes	No
Have tired jaw, mostly in the morning?	Yes	No
Snore or have any other sleep disorders?	Yes	No
Smoke or chew tobacco or its products?	Yes	No
Mouth breathing while awake or sleep?	Yes	No

**Have you ever Experience? (Please circle Yes or No)**

Clicking or popping of your jaw?	Yes	No
Pain around the ear or side of the face?	Yes	No
Difficulty opening or closing the mouth?	Yes	No
Difficulty in chewing?	Yes	No
Headaches, neck, and shoulder aches?	Yes	No
Sore neck and shoulder muscles?	Yes	No

**Have you ever had: (Please circle Yes or No)**

Orthodontic Treatment?	Yes	No
Oral Surgery?	Yes	No
Periodontal treatment?	Yes	No
your teeth and bite adjusted?	Yes	No
A bite plate or night guard?	Yes	No
Serious head or mouth injury?	Yes	No

Do you feel nervous when having dental treatment? Yes No  
if yes, what is your biggest concern? \_\_\_\_\_

Have you ever had an upsetting dental experience? Yes No  
if yes, Pleas describe \_\_\_\_\_

**Are you happy with your teeth appearance?**  Yes  No

**If no, what is it that you want to improve?** \_\_\_\_\_

Is there anything else about your dental history or dental treatment that you would like us to know?

If yes, please explain \_\_\_\_\_

*(Did you complete the other side?)*