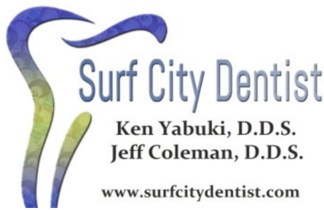

DENTAL HISTORY

Name: ______________________

Today's Date ________________

Appt. Date _________________

Welcome! Please complete this dental history form so that we may provide you with the best possible dental care.

All information is completely confidential.

☐ **Fragrance Free** ☐ **Out of Network Verified** **Referred By:** ____________

Name ____________ Date of Birth ____________ Email ____________

Address ____________ City ____________ State ____________ Zip ____________

What is the reason for your visit today? ____________

Insured (if not pt) ____________ Employer ____________ DOB ____________ SS# ____________

Insurance Co. ____________ Group # ____________ Member ID ____________

Address ____________ City ____________ State ____________ Zip ____________

Previous Dentist Name & Number ____________

Date of Last Dental Visit? ____________ Last Dental Cleaning ____________ Last Full Mouth X-rays ____________

How frequently do you have a dental examination? ____________

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

Have you ever used or are you currently using topical fluoride? ☐ Yes ☐ No

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

Do you have any dental problems now? ☐ Yes ☐ No

If yes, please describe: ____________

Are you seeking information or interested in hearing about any of the following:

Teeth Whitening? ☐ **Yes** ☐ **No**

Cosmetic Dentistry (veneers, full mouth reconstruction, etc)? ☐ **Yes** ☐ **No**

Restorative treatment options (Crowns, Implants, Dentures, etc.)? ☐ **Yes** ☐ **No**

Removable treatment options (Implant supported dentures, All-on-Four, etc.)? ☐ **Yes** ☐ **No**

Snoring and Obstructive Sleep Apnea treatment options? ☐ **Yes** ☐ **No**

Orthodontic Treatment (braces, Invisalign, etc)? ☐ **Yes** ☐ **No**

Are any of your teeth sensitive to:

Hot or cold? ☐ Yes ☐ No

Sweets? ☐ Yes ☐ No

Biting or chewing? ☐ Yes ☐ No

Have you noticed any mouth odors or bad taste? ☐ Yes ☐ No

Do you frequently get cold sores, blisters or any other oral lesions? ☐ Yes ☐ No

Do your gums bleed or hurt? ☐ Yes ☐ No

Have your parents experienced gum disease or tooth loss? ☐ Yes ☐ No

Have you noticed any loose teeth or change in your bite? ☐ Yes ☐ No

Does food tend to become caught in between your teeth? ☐ Yes ☐ No

If yes, where? ____________

Do you:

Clench or grind your teeth while awake or asleep? ☐ Yes ☐ No

Bite your lips or cheeks regularly? ☐ Yes ☐ No

Hold foreign objects with your teeth (pencils, pipe, pins, nails, fingernails)? ☐ Yes ☐ No

Mouth breathe while awake or asleep? ☐ Yes ☐ No

Have tired jaws, especially in the morning? ☐ Yes ☐ No

Snore or have any other sleeping disorders? ☐ Yes ☐ No

Smoke/chew tobacco or other tobacco products? ☐ Yes ☐ No

Have you ever had:

Orthodontic treatment? ☐ Yes ☐ No

Oral surgery? ☐ Yes ☐ No

Periodontal surgery? ☐ Yes ☐ No

Your teeth ground or bite adjusted? ☐ Yes ☐ No

An occlusal guard, night guard or mouth guard? ☐ Yes ☐ No

A serious injury to the mouth or head? ☐ Yes ☐ No

If yes, please describe, including cause ____________

Have you experienced:

Clicking or popping of the jaw? ☐ Yes ☐ No

Pain (joint, ear, side of face)? ☐ Yes ☐ No

Difficulty in opening or closing the mouth? ☐ Yes ☐ No

Difficulty in chewing on either side of the mouth? ☐ Yes ☐ No

Headaches, neck aches, or shoulder aches? ☐ Yes ☐ No

Sore muscles (neck, shoulders)? ☐ Yes ☐ No

Are you satisfied with your teeth's appearance? ☐ Yes ☐ No

Would you like to keep all of your teeth all of your life? ☐ Yes ☐ No

Do you feel nervous about having dental treatment? ☐ Yes ☐ No

If so, what is your biggest concern? ____________

Have you ever had an upsetting dental experience? ☐ Yes ☐ No

If yes, please describe ____________

Have you ever been told to take a pre-medication prior to dental treatment? ☐ Yes ☐ No

Is there anything else about having dental treatment that you would like us to know? ☐ Yes ☐ No

If yes, please describe ____________