Patient Name : _____

DENTAL HISTORY

What is the reason for your visit today? _____

_____

Date of last dental visit _____ **Last dental cleaning** _____ **Last full mouth x-rays** _____

What was done at your last dental visit? _____

_____

Previous dentist's name _____

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? (mouthwash, toothpick, etc.) _____

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 tastes? yes no

Have you noticed any loose teeth or change in bite? yes no

Do you have any allergies to metals? (jewelry, etc.) yes no

Do you clench or grind your teeth? ……..…… yes no

Do you hold foreign objects with your teeth? ……..… yes no

Do you have tired jaws, especially in the morning? yes no

Do you smoke or chew tobacco? ……..... yes no

Have you ever had:

A serious injury to the mouth? ……..... yes no

A bite plate or mouth guard? …..... yes no

Periodontal treatment? ……..…… …….. yes no

Have you experienced:

Clicking or popping of the jaw? ..... yes no

Pain in joint, ear or side of face? …..…….. yes no

Difficulty in opening or closing? …..…….. yes no

Are you satisfied with your teeth's appearance? yes no

Are you interested in whitening you teeth? ……. yes no

Are you nervous about dental treatment? ……. yes no

If so, what is your biggest concern? _____

_____

If you have ever had an upsetting dental experience please describe: _____

_____

Please describe anything else you would like us to know about having dental treatment: _____

_____