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.

DENTAL HISTORY

NAME_____

TODAY'S DATE_____

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_____ Phone#_____

How often do you have dental examinations?_____

How often do you brush your teeth?_____

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

What type of toothbrush do you use? **Manual Electric** (Circle One)

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

If yes, please describe:_____

Please circle the appropriate answer:

Current Problems

Are 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

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

Gum Screening

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

Do you smoke/chew tobacco?.....Yes No

Past Treatment

Have you ever had:

Orthodontic treatment?.....Yes No

Oral Surgery?.....Yes No

Periodontal treatment?.....Yes No

Your teeth ground or the bite adjusted?....Yes No

A splint or mouth guard?.....Yes No

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

If so, please explain_____

_____

Esthetic Evaluation

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_____

Are you self conscious about your teeth when you smile? ..Yes No

Have you ever bleached your teeth?.....Yes No

Do you ever cover your smile with your hand?.....Yes No

Do you wish your teeth were whiter?.....Yes No

Do you wish your teeth were shaped differently.....Yes No

Do you have any discolored teeth?.....Yes No

Have esthetic dental procedures ever been recommended to you?.....Yes No

If yes, please explain_____

_____

How would you rate your smile? **1** through **10** _____

Worst Best

Occlusal Screening

Do you clench or grind your teeth during the day?.....Yes No

Have you ever been made aware of clenching or grinding your teeth at night?.....Yes No

Do you have chronic headaches or neck and shoulder pains?.....Yes No

Are your jaws or teeth tired when you awaken?.....Yes No

Have you ever had pain in your jaw joint, sides of your face or ears?.....Yes No

Have your jaws ever clicked or popped when you open your mouth?.....Yes No

Have you ever experienced difficulty moving your jaw or opening your mouth wide?.....Yes No

Do you chew on only one side of your mouth?.....Yes No

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

If yes, please describe_____

_____

- We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expensed incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature_____Date___/___/_____

Patient/Parent or Guardian/Spouse