(Please see other side also)

DENTAL HISTORY

Patient Name	Medical Alert
I prefer to be called (nickname)	Premedication

We are pleased to welcome you to our practice. We are concerned about you and are eager to provide the best care possible. To help us evaluate your desires, concerns and health, please fill out **BOTH** sides of this form. If you are unsure of a question or don't understand, please ask us. All information is completely confidential.

What is the reason for your visit today? ______________________________

What is your main dental concern?
- ❑ overall good health and dental health maintenance
- ❑ taking care of current problem only

Please enter dates of your last.....

Dental Visit:	Cleaning:	Full mouth X-ray:

What was done at your last visit? ______________________________

Previous dentist's name & location: ______________________________

If patient is a child, do you anticipate any behavior problems or difficulties? ______________________________

Would you like your smile to be better, brighter, or different? ______________________________

Are any of your teeth sensitive to:	
Hot or Cold?	**YES NO**
Sweets?	**YES NO**
Biting or chewing?	**YES NO**
Have you noticed any bad odors or tastes?	**YES NO**
Do your gums bleed or hurt?	**YES NO**
Does food become caught between your teeth?	**YES NO**
Is gum disease or tooth loss common in your family?	**YES NO**
Would you like to keep all your teeth all your life?	**YES NO**
What might prevent you from receiving proper dental care?	
Lack of desire for good health ...	**YES NO**
Inability to miss work/school ...	**YES NO**
Cost of quality care ...	**YES NO**
Do you feel nervous about having dental treatment? If so, what is your biggest concern? ______________	**YES NO**
Have you ever had an upsetting dental experience? If yes, please describe: ______________	**YES NO**

Have you ever had:	
Orthodontics (Braces)	**YES NO**
Oral Surgery	**YES NO**
Periodontal (gum) Treatment	**YES NO**
A bite adjustment, occlusal splint or mouth guard	**YES NO**
An injury to your mouth or head. If yes, explain below.	**YES NO**
Have you ever experienced:	
Clicking or popping of the jaw	**YES NO**
Pain (ears, joints, side of face)	**YES NO**
Difficulty in opening or closing mouth	**YES NO**
Grinding or clenching your teeth	**YES NO**
Sore or tired jaws in the morning	**YES NO**
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, etc.)	**YES NO**
Mouth breathe while awake or asleep?	**YES NO**
Smoke or chew tobacco?	**YES NO**
Frequently get cold sores, blisters, or other lesions?	**YES NO**

Are you satisfied with the appearance and function of your teeth ❑ Yes ❑ No Please Comment ______________________________

Is there anything else about your dental treatment you feel we should know? ______________________________

(PLEASE COMPLETE OTHER SIDE)