

**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.

PATIENT NAME: \_\_\_\_\_

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: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

How often do you have examinations? \_\_\_\_\_ How often do you brush your teeth? \_\_\_\_\_

How often do you floss? \_\_\_\_\_ What other dental aids do you use? \_\_\_\_\_

Do you have any dental problems now? Yes No

If yes, please describe: \_\_\_\_\_

**Are any of your teeth sensitive to:**

Hot or Cold? Yes No

Biting or Chewing? Yes No

Noticed any mouth odors or bad tastes? Yes No

Frequently get cold sores, blisters or any other oral lesions? Yes No

**Have you ever had:**

Orthodontic treatment? Yes No

Root Canal or oral surgery? Yes No

Periodontal gum treatment? Yes No

Your teeth ground or the bite adjusted? Yes No

A bite plate or mouth guard? Yes No

Serious injury to the mouth or head? Yes No

If yes, describe \_\_\_\_\_

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 between your teeth? Yes No

If yes, where? \_\_\_\_\_

**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 chewing on either side? Yes No

Headaches, neckaches, or shoulder aches? Yes No

**Do you:**

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

Hold foreign objects in 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

Smoke or chew tobacco? Yes No

Do you like your teeth's appearance? Yes No

Do you want to keep your teeth forever? Yes No

Are you nervous about dental treatment? Yes No

If so, what is your concern \_\_\_\_\_

Ever had any upsetting dental experience? Yes No

If yes, please describe \_\_\_\_\_

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

If yes, please describe: \_\_\_\_\_

Please complete the other side