Name *(Last, First, M.I.):* | DOB:

DENTAL HISTORY

All answers contained on this questionnaire are strictly confidential and will become part of your dental record.
Please answer the following questions to the best of your ability and recollection.
Thank you for answering the following questions.

What is the reason for your visit today?	
What was done at your last dental visit?	
How often do you have dental cleanings?	
Have you ever been told to take a pre-medication prior to dental treatment?	
How often do you brush your teeth?	
How often do you floss your teeth?	
What other dental aids do you use (toothpick, Waterpik, proxybrushes,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
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 around or between your teeth?	☐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 (fingernails, pencil, pins, etc.)?	☐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

Have you ever had:

Orthodontic treatment?	☐Yes	☐No
Oral surgery?	☐Yes	☐No
Periodontal (gum) treatment?	☐Yes	☐No
Scaling and root planning (i.e. deep cleaning)?	☐Yes	☐No
Your teeth ground or bite adjusted?	☐Yes	☐No
A dental appliance (e.g. retainer, mouth guard, snore guard, sports guard)?	☐Yes	☐No

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?	☐Yes	☐No
Are you satisfied with your teeth's appearance?	☐Yes	☐No
Do you feel nervous about having dental treatment?	☐Yes	☐No
If so, what is your biggest concern? _____		
Have you had an upsetting dental experience?	☐Yes	☐No
If yes, please describe. _____		

Is there anything else about having dental treatment that you would like us to know?

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can compromise my dental treatment and/or experience. It is my responsibility to inform the dental office of any changes in dental status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN DATE