Dental History

Answers to these questions help us provide safe and effective dental care personalized to your individual needs.

ARE ANY OF YOUR TEETH SENSITIVE TO:	**YES**	**NO**
Hot or Cold?	☐	☐
Sweets?	☐	☐
Biting or chewing?	☐	☐
Have you noticed any mouth odors or bad taste?	☐	☐
Do you frequently get oral ulcers?	☐	☐
Do your gums bleed or hurt?	☐	☐
Have you noticed any loose teeth?	☐	☐
Have your teeth shifted over the years?	☐	☐
Does food tend to get caught between your teeth?	☐	☐
DO YOU:		
Clench or grind your teeth while awake or asleep? Have tired jaws, especially in the morning?	☐	☐
Have a hard time opening wide?	☐	☐
Mouth breathe while awake or asleep?	☐	☐
Hold foreign objects with your teeth (i.e. pencils, nails)? Chew ice often?	☐	☐
HAVE YOU EXPERIENCED ANY OF THE FOLLOWING:		
Clicking or popping of the jaw?	☐	☐
Pain in the jaw joint area near the ear?	☐	☐
Difficulty in opening or closing your mouth?	☐	☐
Headaches, neck aches or shoulder aches frequently?	☐	☐
Sore muscles in the neck or shoulders?	☐	☐

I WOULD LIKE TO LEARN MORE ABOUT:

☐ Orthodontics ☐ Cosmetic Dentistry ☐ Sedation Dentistry ☐ Implants ☐ Whitening

☐ Bridges ☐ Veneers ☐ Dentures ☐ Other _____

When was your last dental visit? _____

What was completed during your last dental visit? _____

Last dental x-rays? _____ 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 (electric brushes, toothpick, etc.)? _____

Do you have any dental problems that you are aware of now? If yes, please describe. _____

_____

Do you feel nervous about dental treatment? If yes, what is your biggest concern? _____

_____

_____ _____

Patient or Parent/Guardian Signature *Date*

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