Dental History

Reasons for today's visit_____

Former dentist_____ Former dentist phone #(___)_____

City _____State_____

Date of last dental visit_____ Date of last x-rays_____

How often do you floss_____ How often do you brush_____

Have you ever needed to pre-med before your dental appointments? Yes / No

Are you happy with your smile? Yes / No

If no why? _____

Place a circle on "yes" or "no" to indicate if you have had any of the following

Bad Breath	Yes / No
Bleeding gums	Yes / No
Blisters on mouth	Yes / No
Burning sensation on tongue	Yes / No
Chew on one side of the mouth	Yes / No
Cigarette, pipe or cigar smoking	Yes / No
Clicking or popping of jaw	Yes / No
Dry mouth	Yes / No
Fingernail biting	Yes / No
Food collection between teeth	Yes / No
Broken fillings	Yes / No
Grinding teeth	Yes / No
Gums swollen or tender	Yes / No
Jaw pain or tiredness	Yes / No
Lips and/or cheek biting	Yes / No
Loose teeth	Yes / No
Mouth breathing	Yes / No
Mouth pain	Yes / No
Orthodontic treatment	Yes / No
Pain around the ear	Yes / No
Periodontal treatment	Yes / No
Sensitivity to hot	Yes / No
Sensitivity to sweets	Yes / No
Sensitivity when biting	Yes / No
Sores or growths	Yes / No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patients) health.

_____ _____

Patient Name **Date**

_____

Signature of patient or guardian