Dental History for ________________________________
Patient's Name

Welcome! So that we may provide you with the best possible care, please complete this form as accurately as possible. If you have dental insurance information, please fill the requested information on the reverse. All information is kept confidential.

This information is for: ___ myself ___ my child ___ other________________________

What is the reason for your visit today?____

When was your last dental visit?______________________ What was done?__________________________

Previous Dentist's name & location____

How often do you have dental examinations?____

How often do you brush?______________________ How often do you floss?____________________

Do you feel nervous about having dental treatment?_______ Why?__________________________

Have you ever had an upsetting dental experience?_______ What?__________________________

Do you have any of the following? Please check those that apply:

- ☐ Sensitive teeth
  - ☐ Hot or cold?
  - ☐ Sweets?
  - ☐ Biting / Chewing?
  - ☐ When you breathe in?
  - ☐ Other problem – describe: ______________________________
- ☐ Mouth Odor or bad taste
- ☐ Frequent cold sores, blisters or oral lesions?
- ☐ Do your gums bleed or hurt?
- ☐ Told you have gum disease? When?________________________
- ☐ Do you have loose teeth?
- ☐ Does food "catch" between your teeth? Where?________________________
- ☐ Do you notice a difference in the way your teeth "bite"? ________________
- ☐ Would you like to keep all your teeth all your life?______________________

Do you like the way your teeth look? ☐Yes ☐No

Have you ever had:

- ☐ Periodontal therapy, describe: ______________________________

Do You:

- ☐ Clench or grind your teeth
  - ☐ When asleep?
  - ☐ When awake?
  - ☐ When stressed?
- ☐ Bite foreign objects? (pencils, fingernails, etc.)
- ☐ Bite lip or cheek regularly?
- ☐ Mouth breathe
  - ☐ When asleep?
  - ☐ When awake?
  - ☐ Only when you have a cold?
- ☐ Smoke or chew tobacco? How frequently__________________
- ☐ Do you snore? How frequently__________________
- ☐ Have tired jaws, especially when you wake in the morning?

Do you wake and feel refreshed? ☐Yes ☐No

Have you ever had:

- ☐ Oral surgery, describe: ______________________________

Have you ever had:

- ☐ Orthodontic treatment
- ☐ Teeth removed for spacing
- ☐ Wear a retainer
- ☐ TMJ / TMD treatment
  - ☐ Bite Splint
  - ☐ Mouth guard
  - ☐ Medication for TMJ
  - ☐ Equilibration
  - ☐ Physical Therapy
  - ☐ Counseling
  - ☐ Surgery
- ☐ Serious injury to mouth or head?
- ☐ Clicking or popping in jaw
- ☐ Sore jaw from talking
- ☐ Head, neck or shoulder aches
- ☐ Pain in jaw joint, ear or side of face
- ☐ Difficulty in chewing on both sides of your mouth.
- ☐ Tenderness or difficulty in opening wide.
- ☐ Has you jaw ever locked
  - ☐ Open?
  - ☐ Closed?

- Do you often feel you are excessively tired during the day? ☐ Yes ☐ No
- Has anyone noted difficulty with your breathing patterns at night? ☐ Yes ☐ No
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:____
- If there is anything you would like to change about your teeth or your smile, what would it be?
  ____
- Are you now under the care of a Dental Specialist? ☐ Yes ☐ No
  If yes, please explain:____
- Name of Specialist:____ Phone:______________________

To the best of my knowledge, all of the preceding answers and information provided are true and correct.

____ Date:______________________
Signature of patient, parent or guardian