Name: ____
What is the reason for your visit today? ____
____

Date of Last Dental Visit ______________ **Last Dental Cleaning** _________________ **Last Full Mouth Xrays** ____________________

What was done at your last dental visit? ____

Previous Dentist Name ____________________________________ Telephone ____________________________

Address ____ State _________________

How often do you have dental examinations? ________________ How often do you brush your teeth? ________________________

How often do you floss? ________________________ Have you ever used or are currently using topical fluoride? Yes/No

What other dental aids do you use? (interplak, toothpick, etc.) ____

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
Sweets? Yes No
Biting or Chewing? Yes No
Notice any mouth odor 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 of tooth loss? Yes No
Have you noticed any loose teeth or change in your bite? Yes No
Does food tend to become caught in between your teeth? Yes No
If yes where: ______________________________

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? (pencils, pipes, 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 sleep disorders? Yes No
Smoke/chew/use tobacco products? Yes No
Have you ever had:
Orthodontic treatment? Yes No
Oral Surgery? Yes No
Periodontal treatment? Yes No
Your teeth ground or the bite adjusted? Yes No
A serious injury to the mouth or head? Yes No

Please describe, including cause?
____

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 on either side of the mouth? Yes No
Headaches, neckaches, or shoulder aches? Yes No
Sore muscles (neck, shoulders): Yes No
Are you satisfied with your teeth's appearance? Yes No
Would you like to replace your silver fillings? Yes No
Would you like to keep all of your teeth all of your life? Yes No

Do you feel nervous about having dental treatment? Yes No
Please describe:
____

____
Have you ever had an upsetting dental experience? Yes No
Please describe:
____

____
Have you ever been told to take a pre-medication prior to dental treatment? Yes No

Is there anything else about have dental treatment that you would like us to know? Yes No
If yes, please describe:
____

____