

**Dental Information:**

**Reason for today's visit:** \_\_\_\_\_

**Date of Last Dental visit:** \_\_\_\_\_ **Last Dental Cleaning:** \_\_\_\_\_ **Last Full Mouth X-rays:** \_\_\_\_\_

What was done at your last dental visit? \_\_\_\_\_

Previous Dentist's Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**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? (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

Have you noticed any mouth odors/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 in between  
your teeth?  Yes  No

If yes, where? \_\_\_\_\_

**Do you**

Clench or grind your teeth while awake/asleep?  Yes  No

Bite your lips/cheeks regularly?  Yes  No

Hold foreign objects with your teeth?  
(pencils, pipe, pins, nails, fingernails)  Yes  No

Mouth breathe while awake /asleep?  Yes  No

Have tired jaws, especially in the morning?  Yes  No

Smoke/chew tobacco?  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 bite plate or mouth guard?  Yes  No

A serious injury to the mouth or head?  Yes  No

If so, 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 chewing on either side of  
of the mouth?  Yes  No

Headaches, neck pain or shoulder  
pain?  Yes  No

**Are you satisfied with your teeth's  
appearance?**  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

If so, what is your biggest concern?  
\_\_\_\_\_

Have you ever 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?  Yes  No

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Referred by: \_\_\_\_\_