

PATIENT MEDICAL HISTORY

DENTAL HISTORY

Yes No

- Bad Breath
- Bleeding Gums
- Blisters (mouth or lips)
- Burning Sensation
- Chewing on one side
- Clicking or Popping Jaw
- Dry Mouth
- Fingernail biting

Yes No

- Food collection in teeth
- Foreign objects in mouth
- Grinding teeth
- Gums swollen/tender
- Jaw pain/tiredness
- Lip or cheek biting
- Loose teeth / broken fillings
- Mouth breathing

Yes No

- Mouth pain
- Orthodontics
- Pain around ear
- Periodontal treatment
- Sensitivity to cold
- Sensitivity to heat
- Sensitivity to sweets
- Other

_____ Date of last dental visit? _____ How often do you have dental examinations?
_____ Date of last full mouth x-rays? _____ How often do you brush/floss?
_____ Date of last dental cleaning? _____ What other dental aids do you use?

ADDITIONAL QUESTIONS

Previous hospitalizations / surgeries

Current Physician's Name

Previous Dentist/Office name

What is the reason for your visit today?

Do you have any dental problems now? If yes, please describe

Do you feel nervous about having dental treatment? if yes, what is your biggest concern?

Have you ever had an upsetting dental experience? If yes, please describe

How did you hear about our office?

Patient / Guardian Name: _____

Patient / Guardian Signature: _____

Date: _____