Dental History

Patient Name: Birth Date: Date Created:

Dental Health

Tell us about your smile...

Do you like your smile? ○ Yes ○ No	Do you want to save your teeth? ○ Yes ○ No	Do you want to complete your dental trea ○ Yes ○ No	Do you wear dentures? ○ Yes ○ No
Are you apprehensive about your dental w ○ Yes ○ No	Any problems with your previous dentist? ○ Yes ○ No	Do you chew tobacco? ○ Yes ○ No	

Do you have, or have you ever had, any of the following? (Check all that apply)

Gag easily ○ Yes ○ No	Food catches between your teeth ○ Yes ○ No	Difficutly chewing ○ Yes ○ No	Chew on only one side of your mouth ○ Yes ○ No
Avoid brushing because of pain ○ Yes ○ No	Gums bleed easily ○ Yes ○ No	Gums bleed whenflossing ○ Yes ○ No	Gums feel swollen or tender ○ Yes ○ No
Notice slow-healing sores in mouth ○ Yes ○ No	Discomfort with HOT foods/liquids ○ Yes ○ No	Discomfort with COLD food or liquids ○ Yes ○ No	Discomfort with SWEET or SOUR foods ○ Yes ○ No
Your Jaw makes noise OR gets stuck ○ Yes ○ No	Clench or Grind your teeth frequently ○ Yes ○ No	Jaws feel tired ○ Yes ○ No	Discomfort when chewing or opening wide ○ Yes ○ No
Earaches or pain in front of your ears ○ Yes ○ No	Temporamandibular jaw disorder ○ Yes ○ No	Pain in face, cheeks, jaw joints ○ Yes ○ No	Hade tramuma to the jaw ○ Yes ○ No
Habitually chew gum ○ Yes ○ No	Take fluoride supplements ○ Yes ○ No		

How often do you brush?

How often do you floss?

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 patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____