DENTAL HISTORY

Name _____

Chief Dental Complaint/Reason for Visit: _____

_____

_____

Former Dentist: _____ City: _____ State: _____

Date of last dental visit: _____ Date of last dental x-rays: _____

Please indicate if you have, or have had, any of the following (circle all those that apply):

a) bad breath
b) bleeding gums
c) blisters on lips or mouth
d) burning sensation of tongue or mouth
e) chew on one side of mouth
f) clicking or popping of jaw
g) dry mouth
h) fingernail biting
i) food collection between teeth
j) foreign objects lodged in face or mouth
k) grinding or clenching of teeth
l) swollen or tender gums
m) jaw pain or tenderness
n) lip or cheek biting
o) loose teeth
p) broken fillings
q) mouthguard/bitesplint
r) mouth breathing
s) mouth or tooth pain
t) orthodontic treatment
u) oral surgery
v) periodontal/gum treatment
w) pain around ear
x) sensitivity to temperature, biting, or sweets
y) lumps, growths, sores in mouth or on neck
z) difficult opening or mouth
aa) difficulty chewing
bb) face, mouth or neck injuries

Have you had any serious problems associated with any previous dental treatment? YES NO

If so, please explain _____

_____

Are you satisfied with the appearance of your teeth? YES NO

Please explain _____

Are you satisfied with your ability to chew? YES NO

Please explain _____

How often do you brush? _____

How often do you floss? _____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Date Signature of Patient (or parent/guardian if minor)

For Completion by the Dentist

Significant findings from questionnaire or oral interview: _____

_____

_____

Dental management considerations: _____

_____

_____

_____ _____

Date Signature of Dentist