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Dental Information

Patient Name:_____.
What is the reason for your visit today?_____
Date of Last Dental Visit: _____ Last Dental Cleaning: _____
Last Full Mouth X-rays:_____Last Pano:_____
Previous Dentist's Name:_____
Address: _____
Telephone:_____

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? Please circle: Toothpick, Softpiks, Flosspiks, Sonicare, Oral B, Spinbrush, RX strength toothpaste, MI Paste, Mouthwash, other:_____
Do you have any dental problems now? ☐ Yes ☐ No
If so, 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? ☐ Yes ☐ No
bad tastes? ☐ Yes ☐ No
Has anyone told you –you have mouth odor? ☐ Yes ☐ No
Do you frequently get cold sores? ☐ Yes ☐ No
Blisters? ☐ Yes ☐ No
any other oral lesions? ☐ Yes ☐ No
Have you had dry mouth? ☐ Yes ☐ No

Have you ever had:
Orthodontic treatment? ☐ Yes ☐ No
Dental Oral Surgery? ☐ Yes ☐ No
Periodontal treatment – deep cleaning? ☐ Yes ☐ No
Periodontal Surgery? ☐ Yes ☐ No
Your teeth ground or the bite adjusted? ☐ Yes ☐ No
Have you ever worn a bite plate, night guard or mouth guard? ☐ Yes ☐ No
Have you ever had: A serious injury to the mouth or head? ☐ Yes ☐ No
If so, please describe, including cause _____

Do your gums bleed or hurt? ☐ Yes ☐ No
Have your parents experienced gum disease? ☐ Yes ☐ No
Have your parents experienced tooth loss? ☐ Yes ☐ No
Have you noticed any loose teeth? ☐ Yes ☐ No
Have you noticed any change in your bite? ☐ Yes ☐ No
Does food tend to become caught in between your teeth? ☐ Yes ☐ No
If yes, where? _____

Have you experienced:
Clicking or popping of the jaw? ☐ Yes ☐ No
Clench or grind your teeth while awake? ☐ Yes ☐ No
asleep? ☐ 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
Have tired jaws, especially in the morning? ☐ 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 keep all of your teeth all of your life? ☐ Yes ☐ No

Do you:
Bite your lips or cheeks regularly? ☐ Yes ☐ No
Hold foreign objects with your teeth? ☐ Yes ☐ No
pencils, pipe, pins, nails, fingernails? ☐ Yes ☐ No
Mouth breathe while awake or asleep? ☐ Yes ☐ No
Snore or have any other sleeping disorders? ☐ Yes ☐ No
Smoke/chew tobacco or use other tobacco products? ☐ Yes ☐ No

Would you be interested in tooth
Whitening procedures? ☐ Yes ☐ No
Oral cancer screening? ☐ Yes ☐ No
Bacterial Decontamination? ☐ Yes ☐ No
Orthodontic treatment ☐ 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: _____

Children:
Has child complained about dental problems? ☐ Yes ☐ No
If so, explain:_____
Does child brush teeth daily? ☐ Yes ☐ No
Does child use floss every day? ☐ Yes ☐ No
Is fluoride taken in any form? ☐ Yes ☐ No
Any mouth habits – thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc?
_____