Dental History Form

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Patient Name: First:_____Last:_____Birth Date:_____

Previous Dentist's Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone Number: _____

Date of Last:

Dental visit	Dental Cleaning	Full Mouth X-ray

Do you have any of the following?	YES	NO
Fillings in the last three years?	○	○
Family history of extensive decay or periodontal disease?	○	○
Oral surgery?	○	○
Dry mouth or excessive thirst?	○	○
Sensitivity to hot, cold, pressure or sweets?	○	○
Swelling or lumps in your mouth?	○	○
Difficulty chewing and/or opening or closing your mouth?	○	○
Jaw pain or popping/clicking/snapping in your jaw?	○	○
Headaches, neck aches, or shoulder aches?	○	○
Bleeding, hurting gums or gum disease?	○	○
Loose teeth or change in your bite?	○	○
Clench or grind your teeth while asleep or awake?	○	○
Bite your lips or cheeks regularly?	○	○
Hold foreign objects in your teeth?	○	○
Mouths breathe while awake or asleep?	○	○
Snore or have tired jaws, especially in the morning?	○	○
Smoke/chew tobacco or use tobacco products? How often? _____	○	○
A serious injury to the mouth or head?	○	○
Does food get stuck between certain teeth in your mouth?	○	○
Avoid areas of your teeth while brushing?	○	○
Unpleasant order or taste in your mouth?	○	○
Drink coffee?	○	○
Use Fluoride toothpaste?	○	○
Chew or suck on hard candy, cough drops, or mints? How often? _____	○	○
Use other dental aids? Describe: _____	○	○
Snack between meals?	○	○

Signature: _____Date: _____