

# Dental History

Today's Date: mm|day|yr

Last Name \_\_\_\_\_

First Name \_\_\_\_\_

Initial \_\_\_\_\_

Birthdate mm|day|yr

So that we can provide you with the best possible care, please answer all questions. Your answers are for our records only and will be considered confidential.

What are your main dental concerns? \_\_\_\_\_

\_\_\_\_\_

Are any of your teeth currently sensitive?  Yes  No

if yes, are they sensitive to:  Hot  Cold  Sweets  Pressure

Have you ever had a problem with:

Frequent Decay  Broken Fillings  Fractured Teeth

Have you noticed any mouth odors or bad tastes?  Yes  No

Do your gums hurt or bleed?  Yes  No

Have you noticed any loose teeth or a change in your bite?  Yes  No

Do you have a problem with food impacting between teeth?  Yes  No

Do you clench or grind your teeth?  Yes  No

Do your jaws ever feel tired, hurt, or ache?  Yes  No

Have you ever experienced:

Clicking or Popping of the Jaw?  Yes  No

Difficulty opening or closing your jaw?  Yes  No

Difficulty chewing?  Yes  No

Pain or soreness around your joint or ear area?  Yes  No

Chronic Headaches or facial pain?  Yes  No

Have you ever had an injury or impact to your mouth, jaw or head?  Yes  No

If yes, when and how? \_\_\_\_\_

Do you have any missing teeth?  Yes  No

If yes, have they been replaced?  Yes  No

If yes, by what means?

Fixed Bridge  Removable Partial  Full Denture  Implant

Are you satisfied with your tooth replacement?  Yes  No

Have you ever had any of the following:

Orthodontic treatment  Perodontal (gum) treatment

Oral Surgery  Root Canal Treatment

Bite Adjustment | Bite Plate  TMJ Treatment

Have you ever had a problem associated with previous dental treatment?  Yes  No

If yes, please explain: \_\_\_\_\_

What are your goals for your dental care?

I would like to keep my teeth all my life.

I would like to eat and drink comfortably.

I would like to improve the appearance of my smile.

\_\_\_\_\_ Other

The doctors regularly record interviews or procedures using audio, video or photography. I give my permission for this information to be collected.

Patient/Guardian Signature \_\_\_\_\_ Month | Day | Year



Doctor's Review

Reviewed mm | day | yr Doctor \_\_\_\_\_

**WHERE ART MEETS SCIENCE**

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