

Dental History

Patient Name:

Birth Date:

Date Created:

Dental Health Questions

Which of the following describe your dental history?

Using Teeth as a Tool	☐ Yes ☐ No	Chewing Ice	☐ Yes ☐ No	Playing an Instrument with a Mouthpiece	☐ Yes ☐ No	Biting Nails/Foreign Objects	☐ Yes ☐ No
Tongue/Lip Piercing	☐ Yes ☐ No	Pain or Bleeding when Brushing	☐ Yes ☐ No	Current Orthodontic Treatment	☐ Yes ☐ No	Teeth Sensitive to Temperature, Pressure	☐ Yes ☐ No
Periodontal (Gum) Disease	☐ Yes ☐ No	Previous Orthodontic Treatment	☐ Yes ☐ No	Wearing a Dental Appliance	☐ Yes ☐ No	Loose Teeth	☐ Yes ☐ No
Broken Fillings	☐ Yes ☐ No	Swollen or Tender Gums	☐ Yes ☐ No	Mouth Breather	☐ Yes ☐ No	Frequent Blisters on Lips or Mouth	☐ Yes ☐ No
Chewing on One Side of Mouth	☐ Yes ☐ No	Burning Sensation on Tongue	☐ Yes ☐ No	Clicking or Popping of Jaw	☐ Yes ☐ No	Grinding Teeth	☐ Yes ☐ No
Bad Breath	☐ Yes ☐ No	Dentures	☐ Yes ☐ No	Wisdom Teeth Removed	☐ Yes ☐ No	Problems Associated with Previous Dental	☐ Yes ☐ No

How often do you brush your teeth?

Comment

How often do you floss your teeth?

Comment

What's most important to you about your dental health?

Comment

How do you feel about your teeth?

Comment

Please indicate the level of care you would like us to provide:

☐ Emergency Care As Needed☐ Consultation to Solve Specific Problem☐ Routine Exam and Preventative Care☐ Comprehensive Care, Optimal Dental Health

Comments:

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: _____