Dental History

So that we may provide you with the best possible care, please complete the details below. All information is completely confidential.

Date of last Dental visit____ Date of last X-Rays ____

Date of last Cleaning ____ Previous Dentists name ____

How often do you have a dental check up?____

How often do you brush your teeth?____

Do you have any dental problems?____

Are any of your teeth sensitive to:
Hot or Cold? **Y N**
Sweets? **Y N**
Biting or Chewing? **Y N**
Have you noticed a bad taste or odor in your mouth? **Y N**
Do you ever get mouth ulcers or lesions? **Y N**
Have you ever had any previous problems with dental infections? **Y N**

Have you ever had :
Orthodontic Treatment (braces)? **Y N**
Oral Surgery? **Y N**
Periodontal (Gum) Surgery? **Y N**
A bite plate or mouth guard? **Y N**
An injury to your mouth or head? **Y N**

Do You:
Clench or grind you teeth while awake or asleep? **Y N**
Bite your lips/cheeks regularly? **Y N**
Hold objects in your mouth (pens, fingernails, pins)? **Y N**
Breathe through your mouth while awake or asleep? **Y N**
Have a tired jaw (especially in the morning)? **Y N**
Do your gums bleed or hurt? **Y N**
Do you smoke or chew tobacco? **Y N**
Have your parents lost teeth or had gum disease? **Y N**
Have you noticed any loose teeth or a change in your bite? **Y N**

Have you experienced :
Clicking or popping of the jaw? **Y N**
Pain in your Jaw, ear or face? **Y N**
Difficulty in opening or closing your mouth? **Y N**
Problems with chewing? **Y N**
Headaches or neck aches? **Y N**

Do you tend to get food caught between your teeth? **Y N**
If yes where____

Do you feel nervous when having dental treatment? **Y N**
If so what is your biggest concern?____

Have you ever had an upsetting dental experience? **Y N**
If yes please specify____

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Is there anything else about having dental treatment that you would like to know?____

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