Patient Name		DENTAL HISTOR	
Patient Account No.	Medical Alert		

Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.

United of Last Dental Visit Last Dental Cleaning Last Full Mouth X-rays  What was done at your last dental visit?  Previous Denist's Name  Address State Zip  How offen do you have dental examinations?  How offen do you have dental examinations?  How offen do you foss?  How offen do you foss?  How offen do you foss?  Have you ever used or are currently using topical fluoride? Yes No  What other dental adds do you use? (Interplatik, toothipick, etc.)  Do you have any dental problems now? Yes No If yes, please describe:  Are any of your teeth sensitive to:  Have you ever had:  Orla Surger?  Yes No Oral Surger?  Yes No Oral Surger?  Yes No Periodonial frestment?  Yes No Periodonial frestment?  Yes No Your feeth ground or the bite adjusted?  Yes No Periodonial frestment?  Yes No Your feeth ground or the bite adjusted?  Yes No Periodonial frestment?  Yes No A bite plate or mouth guard?  Yes No Periodonial frestment?  Yes No Have you noticed any toose teeth or change in your bite?  No A serious injury to the mouth or head?  Yes No Periodonial frestment?  Yes No Pilease describe, including cause  No Pilease describe including cause  No Pilease describe with your feeth your feeth?  Yes No Difficulty in opening or obsing the end of head?  Yes No Difficulty in opening or obsing the end of head?  Yes No Difficulty in opening or obsing the end of head?  Yes No Difficulty in opening or obsing the end of head?  Yes No Some on have any other selenging disonate?  Yes No Would you like to keep all of your feeth all of your file?  Yes No Would you like to keep all of your feeth all of your file?  Yes No Would you like to keep all of your feeth all of your file?  Ye	What is the reason for your visit today	?			
What was done at your last dental visit?	Date of Last Dental Visit	Last Dental Cleaning		Last Full Mouth X-rays	
Address	What was done at your last dental visit?				
Address	Previous Dentist's Name			Telephone	
How often do you have dental examinations?  How often do you brush your teeth?  How often do you floss?  How often do you floss?  How often do you floss?  Are any of your teeth sensitive to:  Hot or cold?  Yes No Orhodonic treatment?  Yes No Orhodonic treatment?  Yes No Orhodonic treatment?  Yes No Orhodonic treatment?  Yes No Oral Surger?  Yes No Oral Surger?  Yes No Periodonial treatment?  Yes No Periodonial treatment?  Yes No Periodonial treatment?  Yes No Oral surger?  Yes No Periodonial treatment?  Yes No Periodonial treatment?  Yes No A bite plate or mouth guard?  Yes No A bite plate or mouth guard?  Yes No A serious injury to the mouth or head?  Yes No Please describe, including cause  Have you experienced:  No Do your guard to the power plate or or charge in your bite?  Yes No Please describe, including cause  Have you experienced:  No Do your guard to the jaw?  Yes No Difficulty in opening or closing the mouth?  Yes No Difficulty in opening or closing the mouth?  Yes No Difficulty in opening or closing the mouth?  Yes No Difficulty in opening or closing the mouth?  Yes No Difficulty in opening or closing the mouth?  Yes No Difficulty in opening or closing the mouth?  Yes No Difficulty in opening or closing the mouth?  Yes No Difficulty in opening or closing the mouth?  Yes No Difficulty in opening or closing the mouth?  Yes No Difficulty in opening or closing the mouth?  Yes No Sore muscles (neck, shoulders)?  Yes No Mouth breathe while awake or asleep?  Yes No Sore or have any other sleeping disorders?  Yes No Would you like to keep all of your teeth all of your life?  Yes No Please describe  Have you ever bean told to take a pre-medication prior to dental treatment?  Yes No Please describe  Have you ever been told to take a pre-medication prior to dental treatment?  Yes No Would you like to replace your siver fillings?  Yes No Please describe					
Have you ever used or are currently using topical fluoride? Yes No What other dental aids do you use? (Interplak, toothpick, etc.)  Do you have any dental problems now? Yes No if yes, please describe:  Are any of your teeth sensitive to: Hot or cold? Yes No Orthodontic treatment? Yes No Sweets? Yes No Oral Surgery? Yes No Have you noticed any mouth odors or bad tastes? Yes No Have you noticed any mouth odors or bad tastes? Yes No Do your feequently get cold sores, blisters or any other oral lesions? Yes No Do your feequently get cold sores, blisters or any other oral lesions? Yes No Have your noticed any lose teeth or change in your bite? Yes No Does food tend to become caught in between your teeth? Yes No Do you:  Do you:  Do you:  Do you:  Do you: Clench or grind your teeth while awake or asleep? Yes No Mouth breathe while awake or asleep? Yes	How often do you have dental examina	ations?			
Minat other dental aids do you use? (Interplak, toothpick, etc.)    Do you have any dental problems now? Yes No If yes, please describe:	How often do you brush your teeth?		How often do	you floss?	
What other dental aids do you use? (Interplak, toothpick, etc.)  Do you have any dental problems now? Yes No If yes, please describe:  Are any of your teeth sensitive to:  Have you ever had:  Hot or cold? Yes No Orthodonic treatment? Yes No Oral Surgeny? Yes No					
Are any of your teeth sensitive to: Hot or cold? Yes No Sweets? Yes No Oral Surgery? Yes No Oral Surgery? Yes No Oral Surgery? Yes No Periodontal treatment? Yes No A bite plate or mouth guard? Yes No A bite plate or mouth guard? Yes No A serious injury to the mouth or head? Yes No Please describe, including cause  Have you noticed any loose teeth or change in your bite? Yes No Do your grams bleed or hurt? Yes No Have you noticed any loose teeth or change in your bite? Yes No Does food tend to become caught in between your teeth? Yes No Difficulty in opening or closing the mouth? Yes No Difficulty in opening or closing the mouth? Yes No Difficulty in opening or closing the mouth? Yes No Difficulty in opening or closing the mouth? Yes No Difficulty in opening or closing the mouth? Yes No Difficulty in opening or closing the mouth? Yes No Difficulty in opening or closing the mouth? Yes No Difficulty in opening or closing the mouth? Yes No Difficulty in opening or closing the mouth? Yes No Difficulty in opening or closing the mouth? Yes No Difficulty in opening or closing the mouth? Yes No Difficulty in opening or closing the mouth? Yes No No Difficulty in opening or closing the mouth? Yes No No Difficulty in opening or closing the mouth? Yes No No Difficulty in opening or closing the mouth? Yes No No Nore muscles (neck, shoulders)? Yes No No Nore muscles (neck, shoulders)? Yes No No Nore or have any other sleeping disorders? Yes No Nonote heather while awake or asleep? Yes No Nonote heather while awake or asleep? Yes No Nonote heather while awake or asleep? Yes No No Nore muscles (neck, shoulders)? Yes No Nould you like to replace your silver fillings? Yes No No Novel to replace your silver fillings? Yes No No Novel to replace your silver fillings? Yes No No Novel to replace your silver fillings? Yes No No Novel to replace your silver fillings? Yes No No Novel to replace your silver fillings? Yes					
Hot or cold? Yes No Orthodontic treatment? Yes No Sweets? Yes No Oral Surgepy? Yes No Periodontal treatment? Yes No Your teeth ground or the bite adjusted? Yes No A bite plate or mouth guard? Yes No A bite plate or mouth guard? Yes No A serious injury to the mouth or head? Yes No A serious injury to the mouth or head? Yes No Have you noticed any loose teeth or change in your bite? Yes No Have you noticed any loose teeth or change in your bite? Yes No Have you noticed any loose teeth or change in your bite? Yes No Have you experienced:  Does food tend to become caught in between your teeth? Yes No Difficulty in opening or closing the mouth? Yes No Difficulty in opening or closing the mouth? Yes No Difficulty in opening or closing the mouth? Yes No Difficulty in opening or closing the mouth? Yes No Sore muscles (neck, shoulders)? Yes No Headaches, neckaches or shoulder aches? Yes No Hold foreign objects with your feeth? (pencils, pipe, etc.) Yes No Headaches, neckaches or shoulder aches? Yes No Have tired jawn, especially in the morning? Yes No None or have any other sleeping disorders? Yes No Snoke/chew tobacco or use other tobacco products? Yes No Snoke/chew tobacco or use other tobacco products? Yes No Please describe  Have you ever had an upsetting dental treatment? Yes No Please describe  Have you ever had an upsetting dental treatment that you would like us to know? Yes No Is there anything else about having dental treatment that you would like us to know?	Do you have any dental problems now	? Yes No If yes, please describ	oe:		
Hot or cold? Yes No Orthodontic treatment? Yes No Sweets? Yes No Oral Surgery? Yes No Hother oral lesions? Yes No Oral Surgery? Yes No Periodontal treatment? Yes No Have you noticed any mouth odors or bad tastes? Yes No Hother oral lesions? Yes No Abite plate or mouth guard? Yes No Aserous injury to the mouth or head? Yes No Aserous injury to the mouth or head? Yes No Have you noticed any loose teeth or change in your bite? Yes No Have you noticed any loose teeth or change in your bite? Yes No Do you.  Do you:  Clench or grind your teeth while awake or asleep? Yes No Difficulty in opening or closing the mouth? Yes No Difficulty in opening or closing the mouth? Yes No Difficulty in opening or closing the mouth? Yes No Difficulty in chewing on either side of the mouth? Yes No Difficulty in chewing on either side of the mouth? Yes No Sore muscles (neck, shoulders)? Yes No Headaches, neckaches or shoulder aches? Yes No Have tired jaws, especially in the morning? Yes No Mouth breathe while awake or asleep? Yes No Snore or have any other sleeping disorders? Yes No Snore or have any other sleeping disorders? Yes No Snoke/chew tobacco or use other tobacco products? Yes No Please describe  Have you ever had an upsetting dental treatment? Yes No Please describe  Have you ever had an upsetting dental treatment that you would like us to know? Yes No Is there anything else about having dental treatment that you would like us to know? Yes No Is there anything else about having dental treatment that you would like us to know?	Are any of your teeth sensitive to:			Have you ever had:	
Biting or Chewing? Yes No Periodontal treatment? Yes No Have you noticed any mouth odors or bad tastes? Yes No Your teeth ground or the bite adjusted? Yes No Abite plate or mouth quard? Yes No Aserious injury to the mouth or head? Yes No Aserious injury to the mouth or head? Yes No Aserious injury to the mouth or head? Yes No Aserious injury to the mouth or head? Yes No Please describe, including cause Have you noticed any loose teeth or change in your bite? Yes No Have you noticed any loose teeth or change in your bite? Yes No Clicking or popping of the jaw? Yes No Have you experienced: Clicking or popping of the jaw? Yes No Difficulty in chewing or potential treatment? Yes No Difficulty in chewing on either side of the mouth? Yes No Difficulty in chewing on either side of the mouth? Yes No Difficulty in chewing on either side of the mouth? Yes No Have tired jaws, especially in the morning? Yes No Mouth breathe while awake or asleep? Yes No Sone muscles (neck, shoulders)? Yes No Sone muscles (neck, shoulders)? Yes No Sone muscles (neck you will you teeth's appearance? Yes No Mouth breathe while awake or asleep? Yes No Mouth breathe while awake or asleep? Yes No Mouth breathe while awake or asleep? Yes No Sonoke/chew tobacco or use other tobacco products? Yes No Would you like to replace your silver fillings? Yes No Sonoke/chew tobacco or use other tobacco products? Yes No Please describe.		Yes	No	Orthodontic treatment?Yes	No
Have you noticed any mouth odors or bad tastes? Yes No Do you frequently get cold sores, blisters or any other oral lesions? Yes No A serious injury to the mouth or head? Yes No A serious injury to the mouth or head? Yes No Have your parents experienced gum disease or tooth loss? Yes No Have you noticed any loose teeth or change in your ble? Yes No Have you noticed any loose teeth or change in your ble? Yes No Have you noticed any loose teeth or change in your ble? Yes No Have you noticed any loose teeth or change in your ble? Yes No Have you experienced:    Does food tend to become caught in between your teeth? Yes No Difficulty in opening or closing the mouth? Yes No Difficulty in chewing on either side of the mouth? Yes No Difficulty in chewing on either side of the mouth? Yes No Bite your lips or cheeks regularly? Yes No Sore muscles (neck, shoulders)? Yes No Headaches, neckaches or shoulder aches? Yes No Mouth breathe while awake or asleep? Yes No Mouth you like to replace your silver fillings? Yes No Somokel/chew tobacco or use other tobacco products? Yes No Mouth you like to keep all of your teeth all of your life? Yes No Mouth you ever been told to take a pre-medication prior to dental treatment? Yes No No Is there anything else about having dental treatment that you would like us to know? Yes No	Sweets?	Yes	No		No
Do you frequently get cold sores, blisters or any other oral lesions? Yes No A serious injury to the mouth or head? Yes No A serious injury to the mouth or head? Yes No Please describe, including cause  Have you noticed any loose teeth or change in your bite? Yes No Have you noticed any loose teeth or change in your bite? Yes No Does food tend to become caught in between your teeth? Yes No Difficulty in opening or closing the mouth? Yes No Difficulty in opening or closing the mouth? Yes No Difficulty in chewing on either side of the mouth? Yes No Difficulty in chewing on either side of the mouth? Yes No Headaches, neckaches or shoulder aches? Yes No Sore muscles (neck, shoulders)? Yes No Hold foreign objects with your teeth? (pencils, pipe, etc.) Yes No Have tired jaws, especially in the morning? Yes No Have tired jaws, especially in the morning? Yes No Would you like to replace your silver fillings? Yes No Smoke/chew tobacco or use other tobacco products? Yes No Would you like to keep all of your teeth all of your life? Yes No Please describe  Have you ever had an upsetting dental treatment? Yes No Please describe  Have you ever had an upsetting dental experience? Yes No No Please describe  Have you ever been told to take a pre-medication prior to dental treatment? Yes No No Is there anything else about having dental treatment that you would like us to know? Yes No No	Biting or Chewing?	Yes	No		No
A serious injury to the mouth or head?	Have you noticed any mouth odors or bad to	astes?Yes	No		No
Do your gums bleed or hurt? Yes No Please describe, including cause Have your parents experienced gum disease or tooth loss? Yes No Have you noticed any loose teeth or change in your bite? Yes No Greek food tend to become caught in between your teeth? Yes No Greek face) Yes No Difficulty in opening or closing the mouth? Yes No Difficulty in chewing on either side of the mouth? Yes No Difficulty in chewing on either side of the mouth? Yes No Difficulty in chewing on either side of the mouth? Yes No Headaches, neckaches or shoulder aches? Yes No Hold foreign objects with your teeth? (pencils, pipe, etc.) Yes No Sore muscles (neck, shoulders)? Yes No Houth breathe while awake or asleep? Yes No Have tired jaws, especially in the morning? Yes No Mare you satisfied with your teeth's appearance? Yes No Howelf in the morning? Yes No Would you like to replace your silver fillings? Yes No Smoke/chew tobacco or use other tobacco products? Yes No Please describe Have you ever had an upsetting dental treatment? Yes No Please describe Have you ever been told to take a pre-medication prior to dental treatment? Yes No Is there anything else about having dental treatment that you would like us to know? Yes No	Do you frequently get cold sores, blisters of	r any other oral lesions? Yes	No		
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Have you noticed any loose teeth or change in your bite? Yes No Does food tend to become caught in between your teeth? Yes No If yes, where	Do your gums bleed or hurt?	Yes	No	Please describe, including cause	
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If yes, where			No		
Difficulty in opening or closing the mouth? Yes No  Do you:  Clench or grind your teeth while awake or asleep? Yes No Bite your lips or cheeks regularly? Yes No Headaches, neckaches or shoulder aches? Yes No Headaches, neckaches or shoulder aches? Yes No Hold foreign objects with your teeth? (pencils, pipe, etc.) Yes No Mouth breathe while awake or asleep? Yes No Have tired jaws, especially in the morning? Yes No Snore or have any other sleeping disorders? Yes No Smoke/chew tobacco or use other tobacco products? Yes No  Do you feel nervous about having dental treatment? Yes No  Do you feel nervous about having dental experience? Yes No Please describe Have you ever had an upsetting dental experience? Yes No Is there anything else about having dental treatment that you would like us to know? Yes No  No Since or have any other sleeping disorders? Yes No N	Does food tend to become caught in between	en your teeth?Yes	No		
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Do you feel nervous about having dental treatment?  Please describe Have you ever had an upsetting dental experience?  Have you ever been told to take a pre-medication prior to dental treatment?  Yes No  Is there anything else about having dental treatment that you would like us to know?  Yes No				would you like to keep all of your teeth all of your life? res	NO
Please describe					
Have you ever had an upsetting dental experience?  Please describe Have you ever been told to take a pre-medication prior to dental treatment?  Is there anything else about having dental treatment that you would like us to know?  Yes No					No
Please describe					N.
Have you ever been told to take a pre-medication prior to dental treatment?  Is there anything else about having dental treatment that you would like us to know?  Yes  No					INO
Is there anything else about having dental treatment that you would like us to know?Yes No	Please describe				
• • •	Have you ever been told to take a pre-med	ication prior to dental treatment?		Yes	No
If yes, please describe					No
	If yes, please describe				

(Please complete other side)