Patient Name: _____ Date: _____

DENTAL HISTORY

What is the reason for your visit today? _____

_____

What is your previous dentist's name, address, and phone number?
Name: _____ Phone Number: _____
Address: _____State_____Zip_____

Date of your last dental visit: _____ Reason: _____
Date of most recent dental x-rays: _____

How often do you usually have dental cleanings? (circle one) **3**mos **4**mos **6**mos **12**mos **>12**mos

How often do you brush your teeth? _____ How often do you floss? _____

Please circle Yes or No to the following and briefly explain any yes responses:

		Dates/Explanations
Y N	unhappy with the appearance of your teeth	
Y N	nervous about having dental treatment	
Y N	unfavorable past dental experience	
Y N	problems with dental anesthetic	
Y N	history of orthodontic treatment (braces)	
Y N	history of oral surgery/extractions	
Y N	serious injury to the mouth or head	
Y N	history of periodontal treatment (surgeries, deep cleanings)	
Y N	bleeding gums	
Y N	loose teeth	
Y N	problems with food getting caught between teeth	
Y N	problems with dry mouth	
Y N	unpleasant odor or taste in your mouth	
Y N	areas of mouth sensitive (to hot, cold, sweets, biting, chewing)	
Y N	suffer from cold sores, fever blisters, or other oral lesions	
Y N	snore	
Y N	mouth guard (for athletics, snoring, grinding, TMJ pain, etc)	
Y N	jaw problems (clicking, popping, or pain in the joint)	
Y N	difficulty opening your mouth widely	
Y N	clench or grind your teeth	
Y N	tension headaches	
Y N	difficulty swallowing	

If you have a partial or complete denture, please complete the following:
Has your present denture been relined? Yes No If yes, when? _____
Is your present denture a problem now? Yes No If yes, describe: _____
When did you receive your first partial or complete denture? _____
How long have you been wearing your present denture? _____

Patient/Guardian Signature _____ **Date** _____
Doctor Remarks:

Doctor's Signature_____**Date**_____