

Dental History

Name: _____

Date: __/__/____

How did you find our office? Internet Search Newspaper Phonebook Insurance Listing

Referred (By Whom): _____

Describe your chief concern: _____

Date of Last: **Exam** _____ **Cleaning** _____ **Full Mouth X-rays** _____

How often do you? **Brush** _____ **Floss** _____ **Mouthrinse** _____

What type of toothbrush do you use? (**Manual / Electric**) (**Hard / Med / Soft**)

Do You:

- Clench / grind teeth at night?
- Have tired jaws in the morning?
- Smoke / Chew Tobacco?
- Drink Soda / Energy Drinks? How much? (_____ Cans/day)
- Drink Coffee / Red Wine / Tea
- Chew gum?
- Snack frequently / have a sweet tooth?
- Have any sensitive teeth? (Sweets / Cold / Biting)
- Experience bleeding when you brush / floss?
- Have any missing teeth?
- Have crowded / crooked teeth?
- Have frequent cold sores? Have frequent dry mouth?
- Have any swollen or painful areas in your mouth?

How do you feel about:

(I love it / Could be better / Lets talk about it)

Your smile:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The color of your teeth:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The shape / position of your teeth:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any black mercury fillings you may have:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please describe anything else you would like discussed today: _____

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.

PATIENT SIGNATURE: _____ DATE: _____