

**PATIENT NAME:**

1. Last dental visit? \_\_\_\_|\_\_\_\_|\_\_\_\_ Last cleaing? \_\_\_\_|\_\_\_\_|\_\_\_\_ Date of last x-rays? \_\_\_\_|\_\_\_\_|\_\_\_\_  
 Name of Previous Dentist: \_\_\_\_\_ Phone Number: \_\_\_\_\_

2. How often do you brush? 1 2 3 times per: Day Week Month Other \_\_\_\_\_  
 How often do you floss? 1 2 3 times per: Day Week Month Other \_\_\_\_\_  
 Have you ever received formal oral hygiene instructions? Y N Do you use a water pick? Y N  
 Would you like to keep your teeth for your entire life? Y N Do you use mouthwash? Y N  
 Do you use an electric toothbrush? Y N Do you use fluoride rinse? Y N

3. Have you ever had any of the following procedures performed?  
 Orthodontic Treatment Y N Periodontic Treatment Y N Crown and Bridge Y N  
 Endodontic Treatment Y N Periodontic Surgery Y N Fillings Y N  
 Oral Surgery Y N Bone Grafting Y N Dentures/Partials Y N

If you have answered yes to any of the above, please explain.

4. Have you in the past or do you currently experience any of the following?  
 Loose Teeth Y N Blisters or Oral Lesions Y N Grinding or Clenching Y N  
 Mouth Odor Y N Biting Lips or Cheeks Y N Clicking in the Jaw Y N  
 Bad Taste in Mouth Y N Wear a Mouth Guard Y N Sore Neck and Shoulders Y N  
 Changes in Bite Y N Bleeding or Pain in Gums Y N Excessive Stress Y N  
 Food Caught in Teeth Y N Smoke or Chew Tobacco Y N TMJ/TMD Y N  
 Serious Mouth Injury Y N Frequent Headaches Y N Cold Sores Y N

If you have answered yes to any of the above, please explain.

5. Do you feel nervous about having dental treatment performed? Y N  
 6. Have you had an upsetting dental experience in the past? Y N  
 7. Are your teeth sensitive to hot or cold foods or beverages? Y N  
 8. Are your teeth sensitive when you bite down? Y N  
 9. Is there anything else about having dental treatment that you would like to discuss with the doctor? Y N  
 10. How would you say you feel about the appearance of your teeth? \_\_\_\_\_  
 11. If you could change the appearance, what would you change? \_\_\_\_\_

I understand the above information is necessary to provide myself with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health.

X \_\_\_\_\_  
 Patient Signature

\_\_\_\_\_|\_\_\_\_\_|\_\_\_\_\_  
 Date

X \_\_\_\_\_  
 Doctor Signature

**ALERTS:****DENTAL HISTORY**