

Patient Name: _____ **Date of Birth:** _____ **Today's date:** _____

What is the reason for your visit today?

Date of last dental cleaning: _____ Date of last dental visit: _____ Date of last x-rays: _____

What was done at your last dental visit?

Previous dentist's name: _____ City: _____ State: _____

How often do you?

Brush your teeth? _____ Floss? _____ Have dental examinations? _____

What other dental aids do you use? (Sonicare, toothpick, etc.)

Do you have any dental problems now? Yes / No

If yes, please describe:

Are any of your teeth sensitive to?

- Yes / No Hot or Cold?
- Yes / No Sweets?
- Yes / No Biting or Chewing?
- 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 Do your gums bleed or hurt?
- Yes / No Have your parents experianced gum disease or tooth loose?
- 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?
If yes, where?

Do you? Yes / No Clench or grind your teeth while awake or asleep?

Yes / No Bite your lips or cheeks regularly?

Yes / No Hold foreign objects with your teeth? (pencils, pens, nails, fingernails)

Yes / No Mouth breath while awake or asleep?

Yes / No Have tired jaws, especially in the morning?

Yes / No Snore or have other sleeping disorders?

Have you ever had?

Yes / No Orthodontic treatment?

Yes / No Oral surgery?

Yes / No Periodontal gum treatment?

Yes / No Your teeth ground or bite adjusted?

Yes / No A bite plate or mouth guard?

Yes / No A serious injury to the mouth or head?

If so, Please describe:

Have you experienced?

Yes / No Clicking or popping of the jaw?

Yes / No Pain? (joint, ear, side of face)

Yes / No Difficulty in opening or closing your mouth?

Yes / No Difficulty in chewing on either sides of your mouth?

Yes / No Headaches, neckaches or sholder aches?

Yes / No Sore muscles (Neck, sholders)?

Do you feel nervous about having dental treatment? Yes / No

If so, what is your biggest concern?

Is there anything else about having dental treatment that you would like us to know? Yes / No

If yes, please describe:
