

**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 experienced 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:  
\_\_\_\_\_  
\_\_\_\_\_