Center for Beautiful Smiles
FAMILY, COSMETIC & SEDATION DENTISTRY

Dental History

1. What is the reason for today's visit? ______
2. Date of Last Dental Visit ______ Last Cleaning ______ Last Full Mouth X-rays ______
3. What was done at your last dental visit? ______
4. If you wish us to obtain your previous dental records, please provide the following: ______
   Previous Dentist's Name ______ Telephone ______
   Address ______
5. How often do you have dental examinations? ______
6. How often do you brush your teeth? ______ How often do you floss? ______
7. What other dental aids do you use? Electric Toothbrush ______ Toothpick ______ Water Irrigator ______ Other ______
8. Do you have any dental problems now? Yes ______ No ______
   If yes, please describe: ______

Are any of your teeth sensitive to:

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 you parents experienced gum disease or tooth loss?	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?	Yes	No

If yes where?

______

Do you?

Clench or grind your teeth while awake or asleep?	Yes	No
(pencils, pipe, pins, nails, fingernails)		
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth?	Yes	No
Regularly chew ice or other hard foods?	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Smoke and/or chew tobacco?	Yes	No

If yes, how much per day?

______

Have you ever had:

Orthodontic treatment?	Yes	No
Oral surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground down or your bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No

If so, please describe, including cause

______

Have you experienced:

Clicking, popping or grating sounds of the jaw?	Yes	No
Pain? (joint, unexplained teeth or face, behind the eyes)?	Yes	No
Difficulty in the opening or closing the mouth (locking jaw)?	Yes	No
Limited mouth opening?	Yes	No
Headaches, neck aches or shoulder aches?	Yes	No
Sore or stiff muscles (jaw, neck, shoulders)?	Yes	No
Snoring or Sleep Apnea?	Yes	No
Ear aches, stuffiness or ringing of the ears?	Yes	No
Difficulty swallowing?	Yes	No
Are you satisfied with the appearance of your teeth?	Yes	No
Would you like to keep your teeth all of your life?	Yes	No
Would you like to improve your smile?	Yes	No
Do you feel nervous about having dental treatment?	Yes	No

If so what is your biggest concern?

______

Have you ever had an upsetting dental experience?	Yes	No

If, yes, please describe

______

Is there anything else about having dental treatment that you would like us to know? Yes No
If yes, please describe ______

______

Patient Name: ______ Date: ______