Patient Name: _____

Patient/Parent Signature : _____ **Date:** _____

All information is completely confidential.

What is the reason for your visit today? _____

_____

Date of Last Dental Visit? _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

Have you ever used or are you currently using topical fluoride? ☐ Yes ☐ No

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

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 taste? ☐ 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 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
Bite your lips or cheeks regularly? ☐ Yes ☐ No
Hold foreign objects with your teeth (pencils, pipe, pins, nails, fingernails)? ☐ Yes ☐ No
Mouth breathe while awake or asleep? ☐ Yes ☐ No
Have tired jaws, especially in the morning? ☐ Yes ☐ No
Snore or have any other sleeping disorders? ☐ Yes ☐ No
Smoke/chew tobacco or use other tobacco products? ☐ Yes ☐ No

Have you ever had:

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

If yes, please describe, including cause _____

Have you experienced:

Clicking or popping of the jaw? ☐ Yes ☐ No
Pain (joint, ear, side of face)? ☐ Yes ☐ No
Difficulty in opening or closing the mouth? ☐ Yes ☐ No
Difficulty in chewing on either side of the mouth? ☐ Yes ☐ No
Headaches, neck aches or shoulder aches? ☐ Yes ☐ No
Sore muscles (neck, shoulders)? ☐ Yes ☐ No
Are you satisfied with your teeth's appearance? ☐ Yes ☐ No
Would you like to keep all of your teeth all of your life? ☐ 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 _____

Have you ever been told to take a pre-medication prior to dental treatment? ☐ Yes ☐ No

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

If yes, please describe _____