Vibrant DENTAL
the confident smile specialists

DENTAL HISTORY

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 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?
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 Orthdontic 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?

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, neck aches or shoulder aches?
Yes / No Sore muscles (Neck, shoulders)?

If so, Please describe:

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:

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