

Patient Name _____

Are you taking any medications (including over-the-counter) presently? YES NO If yes, please list:

Do you have a present or past history of abusing drugs (legal, illegal or over-the-counter)? YES NO

Are you under the care of a physician? YES NO For what conditions? _____

(Women) Do you suspect you are pregnant? YES NO Are you nursing? YES NO

Have you ever had a blood transfusion? YES NO
Is there anything else we should know about your medical history?

What is the reason for your visit today? _____

Date of Last Dental Visit _____ Last Dental Cleaning _____ Last full Mouth X-rays _____

What was done at your last dental visit? _____

How often do you have dental examinations? _____

Previous Dentist's Name _____ City _____ State _____

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

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

Do you have any dental problems now? YES NO If yes, please describe: _____

Are any teeth sensitive to:

Hot Yes No
Cold Yes No
Sweets Yes No
Biting or Chewing Yes No

Do you:

Bite your lips or cheeks habitually? Yes No
Hold foreign objects with your teeth? Yes No
(pencils, pins, nails, fingernails)
Tear open packages with teeth? Yes No
Chew ice? Yes No
Mouth breathe while awake or asleep? Yes No
Have any oral piercings? Yes No
Frequently get cold sores, blisters or ulcers? Yes No

Have you ever had:

Oral surgery (extractions)? Yes No
Orthodontic treatment (braces)? Yes No
A serious injury to the mouth or head? Yes No
If yes, please describe: _____

Have you experienced:

Clicking or popping of the jaw with pain? Yes No
Difficulty in opening or closing your mouth? Yes No
Difficulty chewing on either side of the mouth? Yes No
Chronic head, neck, or shoulder aches? Yes No
Tired jaws, especially in the morning? Yes No
Clenching or grinding your teeth while awake or asleep? Yes No
Have you had teeth or bite adjusted due to TMJ? Yes No
Do you wear a night or mouth guard? Yes No
Have you had Periodontal (gum) treatment? Yes No
Notices any mouth odors or bad tastes? Yes No
Do your gums bleed or hurt? Yes No
Have your parents experienced gum disease or tooth loss? Yes No
Noticed any loose teeth or changes in your bite? Yes No
Are you interested in saving teeth that need work? Yes No
Smoke/ Chew Tobacco? Yes No
If yes, how long _____ Have you tried to quit? Yes No
Are you satisfied with the appearance of your teeth? Yes No
Interested in whitening? Yes No
Interested in cosmetic changes? Yes No

Is there anything else about having dental treatment you would like us to know (upsetting dental experiences, nervous, etc.)?

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made during the completion of this form.

Signature of: Patient / Parent / Legal Guardian _____ Date _____
(Please circle one)