DENTAL HISTORY

Welcome! *So that we may provide you with the best possible* care*, please complete this dental history form. All information is completely confidential.*

Patient Name_____

Referred by_____

Previous Dentist_____

Most recent Dental exam _____Treatment_____X-ray_____

How often do you have your teeth cleaned? 3mo._____ 4 mo._____ 6 mo._____ 1 year or longer_____

WHAT IS YOUR IMMEDIATE DENTAL CONCERN? _____

_____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:	**YES**	**NO**
1. Unhappy with the appearance of your teeth……..	○	○
2. Unfavorable dental experiences……	○	○
3. Dental fears……	○	○
4. Problems with or bad reactions to dental anesthetic……	○	○
5. Orthodontic treatment (braces) when……	○	○
6. Periodontal (gum) treatment when……	○	○
7. Bleeding gums……	○	○
8. Avoid brushing any part of your mouth……	○	○
9. Part of your mouth is sensitive to temperature……	○	○
10. Sore teeth……	○	○
11. A burning sensation in your mouth……	○	○
12. Difficulty swallowing……	○	○
13. An unpleasant taste or odor in your mouth……	○	○
14. Jaw problems (temporomandibular joint)……	○	○
15. Dry mouth, throat, and or eyes……	○	○
16. Difficulty opening your mouth widely……	○	○
17. Stiff neck muscles……	○	○
18. Awaken with an awareness of your teeth or jaws……	○	○
19. Tension headaches……	○	○
20. Clench or grind your teeth……	○	○
21. Jaw clicking or popping……	○	○
22. Lost any teeth……	○	○

SUPPLEMENTAL DETURE HISTORY:

If you are wearing a partial or complete artificial denture, please complete the following:

YES NO (Please check Yes or No)

○ ○ **Has your present denture been relined?**

When_____

○ ○ **Satisfied with the appearance?**

_____

○ ○ **Satisfied with the comfort?**

_____

○ ○ **Satisfied with the chewing ability?_____**

When did you receive your first partial or complete denture?_____ How long have you worn them?_____