# **Dental History Form**

Patient Name: Jules Lopez Patient Account No. 123-456-000
Medical Alert: Tooth ache

Please complete both sides of this dental/medical history form so that we may provide you with the best possible dental care.

All information is completely confidential.

Date of last dental visit? ********** Last de	intal cleaning: Jimin	wy 201, 2002)	Last full mouth X-Rays:	S years ago
What was done at your last dental visit? Churry				
Previous Dentist's Name: Dr. Arms Curts			Telephone	
Address: 123 Din St. Greenland		State: Arrora	Zip:	1234
How often do you have dental examinations? Not have	Mari			
Now often do you brush your teeth? 3 times a day		How often do yo	Engel one a day	
flave you ever used or are you currently using topical	Daniel Daniel			
		- 1 100		
What other dental aids do you use (Interplak, toothpic				
Do you have any dental problems now? 🗹 Yes 🔲				
If yes, please describe: Those bronchaving softwines for two	days now, and my gum is a	wertings		
Are any of your teeth sensitive to:		Have you ever had:		
Hot or colid?	─ Ves □ No	Orthodontic treatment?		Yes V No
Sweets?	Yes No	Oral surgery?		Yes V No
Siting or chewing?	Yes W No	Periodontal treatment?		Yes V No
lave you noticed any mouth odors or bad taste?	Yes W No	Your teeth ground or the bite adjusted?		☐ Yes ☑ No
Do you frequently get cold sores, blisters or any other oral lesions?	☐ Yes ☑ No	No A serious injury to the mouth or head?		Yes V No
Do your gums bleed or hurt?	✓ Yes ☐ No			Yes V No
flave your parents experienced gum disease		ii yea, piease des	cribe, including cause	
or tooth loss?	Yes V No	Have you experi	enced:	
flave you noticed any loose teeth or change in your bite?	Yes V No	Clicking or popping of the jaw?		☐ Yes ☑ No
Does food tend to become caught in between		Pain (joint, ear, si		Yes No
your teeth?		Difficulty in openi	ng or closing the mouth?	Yes V No
flyes, where?		Difficulty in chewi	ng on either side of the mout	h? Vos No
Do you:		Headaches, neck	aches or shoulder aches?	✓ Yes ☐ No
Clench or grind your teeth white awake or asleep?	■ Plyes □ No	Sore muscles (neck, shoulders)?		Yes No
life your lips or cheeks regularly?	Yes 🔽 No	Would you like to keep all of your teeth all of		7 Vos No
Hold foreign objects with your teeth pencils, pipe, pins, rails, fingernails)?	☐ Yes ☐ No			✓ Yes ☐ No
Mouth breathe while awake or asleep?	Tyes V No	Do you feel nervous about having dental		
fave tired jaws, especially in the morning?	Yes V No	treatment?		Ves No
Snore or have any other sleeping disorders?	✓ Yes ☐ No	If so, what is your biggest concern?  Have you ever had an upsetting dental experience?  If yes, please describe		
Smoke/chew tobacco or use other tobacco				Yes V No
products?	Yes V No			
		r? □Yes ☑N		
tave you ever been told to take a pre-medication price there anything else about having dental treatme			Yes V No	

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and finally educational and legislative lines of reasoning 
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