



Patient Name \_\_\_\_\_

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? \_\_\_\_\_

Previous Dentist's name? \_\_\_\_\_ Reason for leaving? \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Phone \_\_\_\_\_

How often do you have dental examinations? \_\_\_\_\_ How often do you brush? \_\_\_\_\_

What other dental aids do you use (Interplak, toothpick, etc.) \_\_\_\_\_ How often do you floss? \_\_\_\_\_

Do you have any dental problems now? Yes ☐ No ☐

If yes, please describe: \_\_\_\_\_

**Are any of your teeth sensitive to:**

Hot or Cold?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Sweets?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Biting or Chewing?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you noticed any mouth odors or bad tastes?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you frequently get cold sores, blisters or	Yes <input type="checkbox"/>	No <input type="checkbox"/>
any other lesions?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

**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 sleep?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Bite your lips or cheeks regularly?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Hold foreign objects with your teeth?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(pencils, pipe, pins, nails, fingernails)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Mouth breathe while awake or asleep?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have tired jaws, especially in the morning?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Smoke/Chew tobacco?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

**Have you ever had:**

Orthodontic treatment?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Oral Surgery?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Periodontal treatment?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Your teeth ground or the bite adjusted?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
A bite plate or mouth guard?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
A serious injury to the mouth or head?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

If so, please describe, including cause

\_\_\_\_\_

**Have you experienced:**

Clicking or popping of the jaw?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Pain? (joint, ear, side of face)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Difficulty in opening or closing the mouth?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Difficulty in chewing on either side of the mouth?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Headaches, neck aches or shoulder aches?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Sore muscles (neck, shoulders)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

**Are you satisfied with your teeth's appearance?** Yes ☐ No ☐

Would you like to keep all of your teeth your whole 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 \_\_\_\_\_

\_\_\_\_\_

**Is there anything else about having dental treatment that you would like us to know?**

Yes ☐ No ☐

If yes, please describe: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_