Columbia Smiles Family Dentistry

DENTAL HISTORY

Patient Name:_____ **Phone:**_____

Address:_____ **Medical Alert:**_____

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

What is the reason for your visit today?_____.

Date of Last Dental Visit_____ Last Dental Cleaning_____ Last Full Mouth Xrays_____.

What was done at your last dental visit?_____.

Previous Dentist's name?_____ Telephone_____.

Address_____

How often do you have dental examinations?_____.

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

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

Do you have any dental problems now?_____Describe_____

(circle "yes" or "no" to each item below)

Are any of your teeth sensitive to Hot/ Cold	Yes No	**Have you ever had:**	
Are any of your teeth sensitive to Sweets	Yes No	Orthodontic Treatment	Yes No
Have you noticed any mouth odors or bad taste?	Yes No	Oral Surgery	Yes No
Frequently get cold sores, blisters, or lesions	Yes No	Periodontal Treatment	Yes No
Do your gums bleed or hurt?	Yes No	Your teeth ground or bite adjusted	Yes No
Have your parents experienced gum disease	Yes No	A biteplate or mouthguard	Yes No
Have your parents experienced tooth loss	Yes No	A serious injury to the mouth or head	Yes No
Have you noticed any loose teeth or change in your bite	Yes No	If so, describe _____	
Does food tend to become caught in between your teeth	Yes No	_____	
If yes, where_____		**Have you experienced:**	
Do You:		clicking or popping of the jaw	Yes No
Clench your teeth while awake or asleep	Yes No	Pain (joint, ear, side of face)	Yes No
Bite your lips or cheeks regularly	Yes No	Difficulty in opening or closing mouth	Yes No
Hold foreign objects with your teeth	Yes No	Difficulty chewing with either side	Yes No
Mouth breathe while awake or asleep	Yes No	Headaches, neck or shoulder aches	Yes No
Have tired jaws, especially in the morning	Yes No	Are you satisfied with your teeth's appearance	Yes No
Smoke/chew tobacco	Yes No	Would you like to keep all your teeth for life	Yes No
		Do you feel nervous about dental treatment	Yes No
		If so, what is the biggest concern_____	
		_____	
		Have you ever had an upsetting dental experience	Yes No
		If yes, describe_____	
		_____	
		Do you prefer local anesthesia for dental work	Yes No

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe_____

_____