

Dental History Form

Name _____ Date ____/____/____

What is the purpose of your visit today? _____

How long has it been since your last complete dental visit? _____ Are you in any pain or discomfort? Yes No

What is the name and location of your previous dentist? _____

Have you had previous complications with dental treatment? Yes No If yes, please explain: _____

Are you satisfied with the current appearance and function of you teeth and smile? Yes No If no, please explain what you would change:

Have your parents experienced gum disease or tooth loss? Yes No

Oral Hygiene

How often do you brush? _____ What type of toothbrush do you use? Manual Electric Sonic

How often do you floss? Daily Infrequently Never What type of floss do you use? _____

Do you use any mouth rinse? Yes No What kind? _____

Have you ever been instructed on correct brushing and flossing? Yes No

Have you had or are you currently experiencing any of the following? (Please circle answer)

Sensitivity to: Heat cold sweets biting/chewing

Mouth odors or bad tastes? Yes No

Food impaction of spaces between teeth? Yes No

Clenching or grinding of teeth? Yes No

Dry mouth? Yes No

Clicking or popping of the jaw? Yes No

Difficulty opening/closing jaw? Yes No

Head, neck shoulder aches? Yes No

Trauma to head, neck or mouth? Yes No

What previous treatment have you had? (Please circle answer)

Orthodontic treatment: Yes No Periodontal treatment: Yes No Oral Surgery: Yes No

Do you wear any mouth pieces such as retainers, bite plate or mouth guard? Yes No If yes, which type? _____

Do you chew gum? Yes No If yes, how often and for how long? _____

Do you drink softdrinks? Yes No If yes, how much, how often and what kind? _____

Are there any other concerns about dental treatment or previous experiences that you would like us to know? Yes No

If yes, please explain: _____

For dentist/hygienist: additional comments/concerns about above information:

Golsen Family Dentistry