LAKEVILLE ADVANCED DENTAL CARE

DENTAL HISTORY

PATIENT NAME: _____ DATE OF BIRTH: _____MEDICAL ALERT: _____

WELCOME! So that we may provide you with the best possible care
please complete both the medical/dental history forms.
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: _____

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

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

Do you have any dental problems now? Yes No
If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or Cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Any mouth odors or bad taste?	Yes	No
Do you frequently get cold sores, or other oral lesions?	Yes	No
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 between your teeth?	Yes	No

If yes, where? _____

Do You:

Clench or grind your teeth awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Smoke or chew tobacco?	Yes	No

Have you ever had:

Orthodontic Treatment?	Yes	No
Oral Surgery?	Yes	No
Periodontal Treatment	Yes	No
Your bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No

If so, please describe, including cause:
_____

Have you Experienced:

Clicking or popping of the jaw?	Yes	No
Pain? (Joint, ear, side of face)	Yes	No
Difficulty in opening or closing your mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neckaches or shoulder aches? Or sore muscles?	Yes	No
Are you satisfied with your smile?	Yes	No
Do you feel anxious about dental treatment?	Yes	No

If so what is your concern?
_____

Have you ever had an upsetting dental experience?
_____

Is there anything else about having dental treatment that you would like us to know? Yes No
If yes, please describe:_____
_____