DENTAL HISTORY FORM

American Family Dental Care
IMPLANT CENTER & COSMETIC DENTISTRY

Patient Name: **Medical Alert:**

In order that we may provide you with the best possible care, please complete this dental history form
All information is completely confidential.

What is the reason for your visit today?	
Date of last dental visit:	What was done at your last dental visit?
Last cleaning?	
Last full X-rays?	
Previous Dentist`s name	Phone:
Address:	
How often do you have dental examinations?	How often do you floss?
How often do you brush your teeth?	
What other dental aids do you use? Sonicare/ toothpick/ etc.	
Please describe any dental problems you currently have:	

Are your teeth sensitive to:	Hot	Cold
Biting or chewing?	NO	YES
Do you frequently get:		
cold sores?	NO	YES
Blisters?	NO	YES
Any Oral lesions?	NO	YES
Have you noticed any mouth odors or bad taste?	NO	YES
Do your Gums bleed or hurt?		
Have your parents experienced gum diseases or tooth loss?		
Have you noticed any loose teeth or change in your bite?		
Does food tend to become caught in between your teeth?		
If yes, where?		
Do you:		
Clench or grind your teeth while awake or asleep?		
Bite your cheeks or lips frequently?		
Hold objects with your teeth? (pencil. …)		
Bite your fingernails?)		
Mouth breath while awake or asleep?		
have you tired jaws especially in the morning?		
Smoke or chew tobacco?		

Have you ever had:		
Orthodontic treatment?	NO	YES
if yes, do you wear retainers?	NO	YES
Oral surgery?	NO	YES
Periodontal treatment?	NO	YES
your bite adjusted?	NO	YES
Night guard or mouth guard?	NO	YES
A serious injury to the mouth or head?	NO	YES
If yes, please describe:		
Have you experienced:		
Clicking or popping of the jaw?	NO	YES
Pain? Joint/ ear/ side of face?	NO	YES
Difficulty in opening or closing the mouth?	NO	YES
Difficulty in chewing on either side?	NO	YES
Sore muscles in your neck or shoulders?	NO	YES

If you could change something about your smile, what would it be?

Are you interested in using sedation for your appoinment?

Is there anything else about dental treatment you would like us to know? If so, please explain: