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Dental History Form

Patient Name: _____

Are your teeth sensitive to:

Y	N	Hot
Y	N	Cold
Y	N	Biting Pressure
Y	N	Sweets

Y N Are you dissatisfied with your teeth in any way? Shape, color etc?

Y N Do any of your fillings show when you smile?

Y N Have you ever had any teeth removed?

Y N Do you play sports? If so, which ones: _____

Y N Do you avoid any parts of your mouth when brushing?

Y N Do you have an unpleasant taste or odor in your mouth?

Y N Do any of your teeth, fillings, or crowns feel rough or sharp?

Y N Has anyone ever told you that you clench or grind your teeth?

Y N Have you been diagnosed or treated for sleep apnea?

Y N Do you have a history of oral cancer?

Y N Do you have pain around either ear when you open your mouth?

Y N Do you have a fear of dental work?

If yes, please explain: _____

Roughly when was your last full mouth series of X-rays or Panorex? _____

Have you ever been hit in the mouth or face? _____

What else should we know about you? _____

_____

_____

Patient Signature:_____ Date: _____

Doctors Notes:

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