JONES
FAMILY DENTISTRY

DENTAL HISTORY

PATIENT NAME _____ BIRTH DATE _____

Reason for this visit: _____
When was your last dental visit? _____ What was done then? _____
How often did you visit the dentist before then? _____
Previous Dentist (Name and Location): _____
Have you had a complete set of dental films (X-rays) made? If so, When/where? _____
How often do you brush your teeth? _____
How often do you floss your teeth? _____
Is your drinking water fluoridated? _____

Do your gums bleed while brushing or flossing? ○ Yes ○ No
Are your teeth sensitive to hot or cold liquids/foods? ○ Yes ○ No
Are your teeth sensitive to sweet or sour liquids/foods? ○ Yes ○ No
Are any of your teeth painful? ○ Yes ○ No
Do you have any sores or lumps in or near your mouth? ○ Yes ○ No
Have you had any head, neck or jaw injuries? ○ Yes ○ No
Have you ever experienced any of the following problems with your jaw?
- Clicking ○ Yes ○ No
- Pain (Joint, ear, side of face) ○ Yes ○ No
- Difficulty opening or closing ○ Yes ○ No
- Difficulty chewing ○ Yes ○ No

Do you have frequent headaches? ○ Yes ○ No
Do you clench or grind your teeth? ○ Yes ○ No
Have you ever worn a night guard or other appliance? ○ Yes ○ No
Have you noticed any loosening of your teeth? ○ Yes ○ No
Does food tend to become caught between your teeth? ○ Yes ○ No
Have you ever had periodontal (Gum) treatment? ○ Yes ○ No
Have you ever had any difficult extractions in the past? ○ Yes ○ No
Have you ever had any prolonged bleeding following extractions? ○ Yes ○ No
Do you wear dentures or partials? ○ Yes ○ No
If yes, date of delivery: _____
Have you ever received oral hygiene instructions regarding the care of your teeth and gums? ○ Yes ○ No

Have you ever or are you currently being treated for obstructive sleep apnea? ○ Yes ○ No
Do you or have you been told that you snore loudly? ○ Yes ○ No
Do you feel tired, fatigued, or sleepy during the day? ○ Yes ○ No
Has anyone observed that you stop breathing during sleep? ○ Yes ○ No

If you could change anything about your smile, what would you change? _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____