Dental History

Patient name: ______________________ **Medical Alert:** ______________________

Welcome to Palmetto Dental Associates! So that we are able to provide you with the best possible care, please complete this dental history form. All information provided is completely confidential.

What is the reason for your visit today? ______________________
Date of Last Dental Visit ______________________ Date of Last Dental Cleaning ______________
Date of Last Full Mouth X-rays ______________________
What was done at your last dental visit? ______________________

Previous Dentist's Name & Address ______________________
______________________ Phone ______________
How often do you have dental examinations? ______________________
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
Have you noticed any bad mouth odors or tastes?	YES	NO
Do you frequently get cold sores, blisters 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? ______________

Have you experienced:

Clicking or popping of the jaw?	YES	NO
Pain? (joint, ear, side of face)?	YES	NO
Difficulty in opening or closing the mouth?	YES	NO
Difficulty in chewing on either side of mouth?	YES	NO
Headaches, neckaches or shoulder aches?	YES	NO
Sore muscles (neck, shoulders)?	YES	NO
Are you satisfied with your teeth's appearance?	YES	NO
Do you feel nervous about having dental treatment?	YES	NO

If so, what is your biggest concern? ______________________

Do you:

Clench or grind your teeth while awake or asleep?	YES	NO
Bite lips or cheeks regularly?	YES	NO
Hold foreign objects with teeth? (pencils, pipes, pens, fingernails)	YES	NO
Mouth breath while awake or asleep?	YES	NO
Have tired jaws, especially in the morning?	YES	NO
Smoke/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 mouth/head?	YES	NO

If so, please describe: ______________
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Have you ever had an upsetting dental experience? YES NO
If yes, please describe: ______________________

Is there anything else about having dental treatment that you would like us to know? YES NO
If yes, please describe: ______________________

Is there anything you would like to change about your smile? YES NO
If yes, please describe: ______________________

Would you like to know more about dental implants? YES NO

I give permission for my dental chart to be discussed with the following people: ______________________

Signature of patient or guardian: ______________________ **Date:** ______________