WILLIAMS FAMILY DENTAL

440 835-7272

DENTAL HISTORY

We are pleased to welcome you into our practice. So that we may provide you with the best possible care, please complete this dental history form. All information is completely confidential.

Patient Name: _____
What is the reason for your visit today?_____
_____
Date of Last Dental Visit_____ **Last Dental Cleaning**_____ **Last Full Mouth X-rays**_____
What was done at your last dental visit?_____
_____
Previous Dentist's Name_____ Telephone_____
Address_____ City _____State_____ ZIP _____
How often do you have dental examinations? _____
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
Have you noticed any mouth odors or bad tastes?	Yes No
Do you frequently get cold sores, blisters or any 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 in between your teeth?	Yes No
If yes, where? _____	

Do you:

Clench or grind your teeth while awake or asleep?	Yes No
Bite your lips or cheeks regularly?	Yes No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails, etc.)	Yes No
Mouth breathe while awake or asleep?	Yes No
Have tired jaws, especially in the morning?	Yes No
Snore or have any other sleep disorders?	Yes No
Smoke/chew tobacco or use other tobacco products?	Yes No

Have you ever had:

Orthodontic treatment?	Yes No
Oral Surgery?	Yes No
Periodontal treatment?	Yes No
Your teeth ground or 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_____	Yes No
_____	

Have you experienced:

Clicking or popping of the jaw?	Yes No
Pain? (joint, ear, side of the face)	Yes No
Difficulty in opening or closing the mouth?	Yes No
Difficulty in chewing on either side of the 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
Would you like to keep all of your teeth all of your life?	Yes No
Do you feel nervous about having dental treatment?	Yes No
If so, what is your biggest concern?_____	
_____	
Have your 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 _____
_____
_____
_____