Dental History

Answers to these questions help us provide safe and effective dental care personalized to your individual needs.

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 taste?	**YES NO**
Do you frequently get cold sores?	**YES NO**
Do you frequently get oral ulcers?	**YES NO**
Do your gums bleed or hurt?	**YES NO**
Have you noticed any loose teeth?	**YES NO**
Have your teeth shifted over the years?	**YES NO**
Does food tend to become caught in between your teeth?	**YES NO**

DO YOU:

Clench or grind your teeth while awake or asleep? Have tired jaws, especially in the morning?	**YES NO**
Have a hard time opening wide?	**YES NO**
Mouth breathe while awake or asleep?	**YES NO**
Hold foreign objects with your teeth (i.e. pencils, nails)? Chew ice often?	**YES NO**

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING:

Clicking or popping of the jaw?	**YES NO**
Pain in the jaw joint area near the ear?	**YES NO**
Difficulty in opening or closing your mouth?	**YES NO**
Headaches, neck aches, or shoulder aches frequently?	**YES NO**
Sore muscles in the neck or shoulders?	**YES NO**

When was your last dental visit? _____

What was completed during your last dental visit? _____

Last dental x-rays?_____ 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? (electric brushes, toothpick, etc.) _____

Do you have any dental problems that you are aware of now? If yes, please describe. _____

_____

Do you feel nervous about dental treatment? If yes, what is your biggest concern? _____

_____ _____

Patient's Signature or Guardian Date

The BITE DENTAL