Dental History Form

Page 1

Glennhill
FAMILY DENTISTRY

Patients Date of birth

__/__/____

Patient's First Name *

Patient's Last Name *

Are you the patient or are you filling out the forms for them? *

- ○ I am the Patient
- ○ I am filling out for the patient

Dental History Information

Name of your previous dentist

Date of last dental visit

__/__/____

Your last cleaning

__/__/____

Your last oral cancer screening

__/__/____

Your last complete X-rays

__/__/____

What is the most important thing to you about your dental visit today?

Why did you leave your previous dentist?

Name of your previous dentist

Reason for today's visit

How often do you floss your teeth

Have you ever had an oral cancer screening?

○ Yes ○ No

Do your gums bleed when you brush?

○ Yes ○ No

Have you or a family member ever been treated for periodontal disease?

○ Yes ○ No

Have you ever had complications from an extraction?

○ Yes ○ No

Have you ever had a popping or clicking near your ear when you chew?

○ Yes ○ No

Are you prone to frequent headaches?

○ Yes ○ No

Do you grind or clench your teeth?

○ Yes ○ No

Do you have sores, blisters or swelling on your gums lips or cheeks?

○ Yes ○ No

Have you ever had orthodontic treatment?

○ Yes ○ No

Do you snore?

○ Yes ○ No

Do you have problems with bad breath?

○ Yes ○ No

Have you ever had an allergic reaction to a crown, metal filling or dental appliance?

○ Yes ○ No

Have you ever used an electric toothbrush?

○ Yes ○ No

Are your teeth sensitive to hot, cold or pressure?

○ Yes ○ No

Please mark any of the following conditions that apply to you:

Pain/Discomfort

- ☐ Sensitivity (hot, cold, sweet)
- ☐ Pressure
- ☐ Broken teeth/fillings
- ☐ Worn teeth
- ☐ Dry Mouth

Appearance

- ☐ Discolored teeth
- ☐ Worn teeth
- ☐ Misshaped teeth
- ☐ Crooked teeth
- ☐ Spaces
- ☐ Overbite
- ☐ Flat teeth

Function

- ☐ Grinding/Clenching
- ☐ Headaches
- ☐ Jaw Joint (TMJ) pain
- ☐ Jaw Joint (TMJ) pain/popping
- ☐ Bad Bite
- ☐ Speech Impediment
- ☐ Mouth Breathing
- ☐ Sore Muscles (neck, shoulders)
- ☐ Difficulty Opening or Closing
- ☐ Difficulty Chewing on either side

Periodontal (Gum) Health

- ☐ Bleeding, Swollen, Irritated gums
- ☐ Bad breath
- ☐ Loose tipped, shifting teeth
- ☐ Previous perio/gum disease

Habits

- ☐ Thumb sucking
- ☐ Nail-biting
- ☐ Cheek/Lip biting
- ☐ Chewing on ice/foreign objects

Sleep Pattern or Conditions

- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Daytime Drowsiness
- ☐ Bed wetting (for children)

Previous Comfort Options

- ☐ Nitrous Oxide
- ☐ Oral Sedation (Pill)
- ☐ IV Sedation

Tobacco use

○ Yes ○ No

Alcohol use

○ Yes ○ No

Drug use

○ Yes ○ No

Please list family history of any conditions marked:

Page 4

On a scale of 1-5, with 5 being the highest rating:

How important is your dental health to you? *

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Where would you rate your current dental health? *

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Where do you want your dental health to be? *

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

What would you like to change about your smile?

☐ Color ☐ Bite ☐ Chipped Teeth ☐ Spaces

☐ Crowding ☐ Smile Makeover ☐ Missing Teeth ☐ Whiter Teeth

What is the most important thing to you about your future smile and dental health?

Page 5

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 in medical status.

Patient's First Name *

Patient's Last Name *

Signature *

Today's Date

03/29/2023