Date: _____ **Name:** _____ **DOB:** _____

Dental History Questionnaire

Questions	***Answers***
What is the reason for your visit today?	Checkup
	Tooth ache
	Teeth or gums hurting or bothering me
	Other
When was the last time you were seen by a dentist for a teeth cleaning?	
When was the last time you were seen by a dentist for a complete dental examination?	
How often do you have dental examinations?	Twice per year
	Once per year
	Once per two years
	Once per three years
	More than three years between exams
	This is the first time
How many times a day do you brush your teeth?	
How many times a day do you floss?	
How many times a day do you rinse your teeth?	
What type of tooth brush do you use?	Manual
	Electric
	Both
Do you wear dentures or partials?	Yes
	No
If you wear dentures or partials, when were they placed?	
Are you using any other dental devices? (If yes, please use Comments to describe).	Yes
	No
Do you have any dental problems now or feel pain to any of your teeth? (If yes, please use Comments to describe).	Yes
	No
Are your teeth sensitive to any of the following?	Hot or cold
	Sweets
	Biting or chewing
Do you have any sores or lumps in or near your mouth?	Yes
	No
Do your gums bleed while brushing or flossing?	Yes
	No
	Sometimes
Does food tend to become caught in between your teeth?	Yes
	No
Do you clench or grind your teeth?	Yes
	No
Do you bite your lips or cheeks frequently?	Yes
	No

Date: _____ **Name:** _____ **DOB:** _____

Dental History Questionnaire

Questions	***Answers***
Do you hold foreign objects with your teeth (pencils, pipe, pins, nails, fingernails, etc.)?	Yes
	No
Do you breathe through your mouth while awake or asleep?	Yes
	No
Do you have tired jaws, especially in the morning?	Yes
	No
Do you smoke or use tobacco?	Yes
	No
Have you ever had any history of orthodontic treatment (for example: braces, retainer, etc.)?	Yes
	No
If you ever had any history of orthodontic treatment, when was it done?	
Have you ever had any of the following? (if yes, please use Comments to describe).	Oral surgery
	Periodontal treatment
	Gum therapy
	Your teeth ground or the bite adjusted
	A bite plate or mouth guard
	A serious injury to the mouth or head
Have you ever experienced any of the following?	Clicking or popping of the jaw
	Pain in joint, ear, side of face
	Difficulty in opening or closing the mouth
	Difficulty in chewing on either side of the mouth
	Headaches, neckaches or shoulder aches
	Sore muscles (neck, shoulders)
Have you ever had any difficult tooth extractions in the past?	Yes
	No
	Don't remember
Have you ever had any prolonged bleeding following tooth extractions?	Yes
	No
	Don't remember
Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	Yes
	No
Are you interested in doing cosmetic treatment (for example: teeth whitening, straightening teeth, changing smile)?	Yes
	No
Do you like your smile?	Yes

Date: _____ **Name:** _____ **DOB:** _____

Dental History Questionnaire

Questions	***Answers***
Do you like your smile?	No
Is there anything else about having dental treatment that you would like us to know? (Please use Comments to describe).	Yes
	No

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such medical care to third payors and/or health practitioners. I authorize and request my insurance company to pay directly to the doctor or doctor group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature: _____