MOUNT PROSPECT
SMILES
A HEALTHY SMILE TO FIT YOUR LIFESTYLE

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DENTAL HISTORY FORM

Patient Name: _____ Date of Birth: _____

Date of Last Dental Visit: _____/ _____ / _____ Reason for the visit? _____

Date of Last Dental X-rays? _____ / _____ / _____

Circle Appropriate Answer:

1. Are you currently experiencing dental pain/discomfort? YES/NO If YES, explain: _____
2. Do your gums bleed? YES/NO If YES, explain: _____
3. Are your teeth loose? YES/NO If YES, explain: _____
4. Do you wear dentures or partials? YES/NO If YES, explain:_ _____
5. Have you ever told you have gum disease? YES/NO If YES, explain: _____
6. Are your teeth sensitive to hot/cold/sweets or pressure? YES/NO If YES, explain: _____
7. Do you have discomfort in jaw, clicking or popping? YES/NO If YES, explain:_ _____
8. Do you brux or grind your teeth? YES/NO If Yes, explain: _____
9. Do you wear an occlusal guard? YES/NO
10. Have you ever had braces before? YES/NO If Yes, explain: _____
11. Do you have dry mouth? YES/NO If Yes, explain: _____
12. Does food or floss catch between your teeth? YES/NO If Yes, explain: _____
13. Have you had any problems with previous dental care? YES/NO If Yes, explain: _____
14. Do you have anxiety with dental treatment? YES/NO If Yes, explain: _____
15. Have you been pre-medicated for dental treatment? YES/NO If Yes, explain: _____
16. Have you ever had a reaction to anesthetic used with your dental treatment? YES/NO If Yes, explain: _____
17. Are you happy with your smile? YES/NO If No, explain: _____

18. What would you change about the present condition of your mouth? _____

19. Is there anything else you would like us to know about your dental health or dental history? YES/NO If Yes, explain: _____

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful dental history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction.

_____ _____

Signature of Patient (Parent or Guardian) Date

_____ _____

Signature of Dentist Date