ROCKY RIDGE DENTAL ASSOCIATES

Dental History

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_____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other cleaning aids do you use? (waterpik,toothpick,etc.) _____

Do you have any dental problems now? Yes No

If yes, please describe: _____

Are any of your teeth sensitive to
Hot / Cold / Sweets? . . . . . 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 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 objects with your teeth
(pencils, pins, nails, fingernails) . . . . . Yes No
Mouth breathe awake/asleep . . . . . Yes No
Have tired jaws, especially in the
Morning . . . . . Yes No
Snore or have sleeping disorders . . . Yes No
Smoke/chew tobacco products . . . . Yes No

Have you ever had:
Orthodontic treatment . . . . . Yes No
Oral surgery . . . . . Yes No
Periodontal treatment . . . . . Yes No
Your teeth ground or bite adjusted . . . Yes No
Night Guard . . . . . Yes No
A serious injury to the mouth, head . . Yes No
If yes, please describe_____
_____

Have you experienced:
Clicking or popping of the jaw . . . . . Yes No
Pain (joint, ear, side of face) . . . . . Yes No
Difficulty opening or closing mouth . . . Yes No
Difficulty chewing on either side . . . . . Yes No
Head, neck or shoulder pain . . . . . Yes No
Sore muscles (neck, shoulders) . . . . . Yes No

Are you satisfied with your teeth's appearance?
Yes No

If so, what is your biggest concern?
_____

Do you feel nervous about dental treatment?
Yes No

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe _____