Drs. Love & Miller, P.C.

Clear Form

Dental History

Patient Name		Today's Date	
Patient Account No.		Medical Alert	

Welcome! *So that we may provide you with the best possible care please complete the dental and medical history forms. All information is completely confidential.*

1. **What is the reason for your visit today?** _____

2. **What was done at your last dental visit?** _____

Date of last dental visit _____ Last dental cleaning _____ Last x-rays _____

Previous dentist name _____ Phone _____

Address _____ City _____ State _____ Zip _____

3. **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 brush, toothpick, etc.) _____

4. **Do you have any dental problems now?** ☐ Yes ☐ No

If yes, please describe: _____

Check Yes or No			Check Yes or No		
Are any of your teeth sensitive to:			**Have you experienced:**		
Hot or cold?	☐ Yes	☐ No	Clicking or popping of the jaw?	☐ Yes	☐ No
Sweets?	☐ Yes	☐ No	Difficulty in opening or closing the mouth?	☐ Yes	☐ No
Biting or Chewing?	☐ Yes	☐ No	Difficulty in chewing on either side of mouth?	☐ Yes	☐ No
Noticed any mouth odors or bad tastes?	☐ Yes	☐ No	Pain? (joint, ear, side of face)	☐ Yes	☐ No
Do your gums bleed or hurt?	☐ Yes	☐ No	Headaches, neck aches or shoulder aches?	☐ Yes	☐ No
Parent's history of gum disease or tooth loss?	☐ Yes	☐ No	Sore muscles? (neck, shoulders)	☐ Yes	☐ No
Noticed any loose teeth or change in bite?	☐ Yes	☐ No	**Have you ever had:**		
Does food get caught in between your teeth?	☐ Yes	☐ No	Orthodontic treatment?	☐ Yes	☐ No
If Yes, where? _____			Oral surgery?	☐ Yes	☐ No
Do you:			Periodontal treatment?	☐ Yes	☐ No
Get frequent cold sores, blisters or oral lesions?	☐ Yes	☐ No	Your teeth ground or the bite adjusted?	☐ Yes	☐ No
Hold foreign objects with your teeth?			A bite plate or mouth guard?	☐ Yes	☐ No
(Pencils, pipes, pins, nails, fingernails)	☐ Yes	☐ No	A serious injury to the mouth or head?	☐ Yes	☐ No
Clench/grind your teeth while awake or asleep?	☐ Yes	☐ No	If, so please describe, including cause:		
Bite your lips or cheeks regularly?	☐ Yes	☐ No	_____		
Mouth breathe while awake or asleep?	☐ Yes	☐ No	_____		
Have tired jaws, especially in the morning?	☐ Yes	☐ No	_____		
Smoke or chew tobacco?	☐ Yes	☐ No			

5. **Are you satisfied with your teeth's appearance?** ☐ Yes ☐ No
6. **Would you like to keep all of your teeth all your life?** ☐ Yes ☐ No
7. **Do you feel nervous about having dental treatment?** ☐ Yes ☐ No

If yes, what is your biggest concern? _____

8. **Have you ever had an upsetting dental experience?** ☐ Yes ☐ No

If yes, please describe: _____

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

If yes, please describe: _____