Drs. Love
& Miller, P.C.

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 both sides of this medical/dental history form. All information is completely confidential.

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

____

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

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

Previous dentist's 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"	
Are any of your teeth sensitive to:	
Hot or cold?	❒ Yes ❒ No
Sweets?	❒ Yes ❒ No
Biting or Chewing?	❒ 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 your parents experienced gum disease or tooth loss?	❒ 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? If yes, where?	❒ Yes ❒ No
Do you:	
Hold foreign objects with your teeth? (pencils, pipes, pins, nails, fingernails)	❒ Yes ❒ No
Clench or grind your teeth while awake or asleep?	❒ Yes ❒ No
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/chew tobacco?	❒ Yes ❒ No

Check "yes" or "no"	
Have you experienced:	
Clicking or popping of the jaw?	❒ Yes ❒ No
Difficulty in opening or closing the mouth?	❒ Yes ❒ No
Difficulty in chewing on either side of the mouth?	❒ Yes ❒ No
Pain? (joint, ear, side of face)	❒ Yes ❒ No
Headaches, neckaches or shoulder aches?	❒ Yes ❒ No
Sore muscles (neck, shoulders)?	❒ Yes ❒ No
Have you ever had:	
Orthodontic treatment?	❒ Yes ❒ No
Oral Surgery?	❒ Yes ❒ No
Periodontal treatment?	❒ Yes ❒ No
Your teeth ground or the bite adjusted?	❒ Yes ❒ No
A bite plate or mouth guard?	❒ Yes ❒ No
A serious injury to the mouth or head? If so, please describe, including cause:	❒ Yes ❒ No

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

If so, 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: ______________________