ORCHARD DENTAL GROUP™
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# DENTAL HISTORY

***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.*

| PATIENT NAME |
| --- |
| Medical Alert |

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

**Do you have any dental problems now?** Yes No

If yes, please describe: _____

**Date of Last Dental Visit** _____ **What was done at your last visit?** _____

Previous Dentist's Name _____

Address _____ Telephone _____

**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? (Sonicare, Waterpik, toothpick, etc.) _____

| | | |
| --- | --- | --- |
| **Are your teeth sensitive to:** | | |
| Hot or cold? | Yes | No |
| Sweets? | Yes | No |
| Biting or chewing? | Yes | No |
| **Do your gums bleed or hurt?** | Yes | No |
| Have your parents experienced gum disease or tooth loss? | Yes | No |
| Have you ever had treatment for gum problems? | Yes | No |
| Have you noticed any loose teeth or change in your bite? | Yes | No |
| Does food tend to become caught between your teeth? | Yes | No |
| **Do you:** | | |
| Mouth breathe while awake or asleep? | Yes | No |
| Snore? | Yes | No |
| Have tired jaws, especially in the morning? | Yes | No |
| Smoke/chew tobacco? | Yes | No |

| | | |
| --- | --- | --- |
| **Personal Smile Self-Evaluation** | | |
| Do you like your smile? | Yes | No |
| Do you have spaces between your teeth that bother you? | Yes | No |
| If your teeth are crooked or crowded does that bother you? | Yes | No |
| Do you like the size and shape of your teeth? | Yes | No |
| Do you like the color of your teeth? | Yes | No |
| If your smile was improved, would you feel more confident? | Yes | No |
| **Would you like to keep your teeth all of your life?** | Yes | No |
| Do you feel nervous about having dental treatment? | Yes | No |
| Have you ever had an upsetting dental experience? | Yes | No |

What can we do to make your visits as pleasant as possible?

_____
_____
_____

Is there anything else about having dental treatment that you would like us to know?

_____
_____
_____