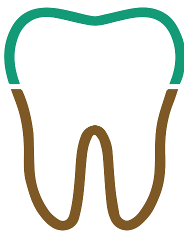

West Hartford
DENTAL GROUP

DENTAL HISTORY

Patient Name ____ **Date of Birth**___________________________

Medical Alert, please specify____

What is the reason for your visit today? ____

If you were able to change anything about your smile, what would you change?____

Date of last Dental Visit________________________ **Last Dental Cleaning**_________________________ **Last Full Mouth X-rays**_____________________
What was done at your last dental visit? ____

Previous Dentist/Dental Group Name____
Address____State___________ Zip____________________ Phone : (____)________________________

How often do you have dental examinations? ____
How often do you brush your teeth? ______________________________________ How often do you floss? _______________________________________

What dental aids do you use? (Hydro floss, Electric Toothbrush, Toothpick) : ____

Do you have dental problems? **Yes/No** If **yes**, please describe: ____

Is there anything else about having dental treatment that you would like us to know about? If so, please describe below:
____

Please circle the correct response:

Are any of your teeth sensitive to:		
hot/cold	yes	no
sweets	yes	no
Biting or chewing	yes	no
Mouth odor/bad breath	yes	no
Do you frequently get cold sores/blisters/lesions?	yes	no
Do your gums bleed or hurt?	yes	no
Have your parents had gum disease or tooth loss?	yes	no
Have you noticed any loose teeth or change in bite?	yes	no
Does food tend to get caught between your teeth?	yes	no
If yes, where? _______________________________		
Do you clench or grind your teeth?	yes	no
Do you bite your lips or cheeks regularly	yes	no
Do you hold foreign objects in your teeth?	yes	no
Do you bite your nails	yes	no
Do you mouth breathe while awake or sleeping?	yes	no
Do you smoke or chew tobacco?	yes	no
Have you ever had orthodontic treatment?	yes	no

Have you ever had:		
Oral surgery?	yes	no
Periodontal treatment?	yes	no
Your bite adjusted?	yes	no
A serious head or mouth injury?	yes	no
If so, please describe:		
____		
Experienced clicking or popping?	yes	no
Experienced pain (joint, ear, face)?	yes	no
Difficulty chewing?	yes	no
Headaches or neckaches	yes	no
Shoulder aches or muscle aches?	yes	no
Are you satisfied with your teeth's appearance?	yes	no
Do you feel nervous about dental treatment?	yes	no
If so, what is your biggest concern?		
____		
Have you ever had an upsetting dental experience?	yes	no
If yes, please describe: ___________________________________		

Doctor's Notes: