HOLT Family & Cosmetic DENTAL CARE

Dental and Health History

To provide you with the best possible care, please complete the dental & medical history form. All information is completely confidential.

What is the reason for your visit today?_____

_____

Date of Last Dental Visit:_____ **Date of Last Cleaning:**_____ **Last of Full Mouth X-rays:**_____

What was done at your last dental visit?_____

_____

Previous Dentist's Name:_____

Address:_____ State_____ Zip_____

Telephone:_____

***HIPPA regulations requires you (the patient) to contact your previous Dentist to release your x-rays**

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, toothpicks, etc.)?_____

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

If yes, please describe:_____

Are any of your teeth sensitive to:

Hot or Cold?	☐ Yes ☐ No
Sweets?	☐ Yes ☐ No
Biting or Chewing?	☐ Yes ☐ No

Do you:

Notice any mouth odors or bad taste?	☐ Yes ☐ No
Frequently get cold sores, blisters or any other oral lesions?	☐ Yes ☐ No

Do your gums bleed or hurt?	☐ Yes ☐ No
Any gum disease in family members?	☐ Yes ☐ No
Tooth Loss?	☐ Yes ☐ No
Have you noticed any loose teeth?	☐ Yes ☐ No
Have you noticed a change in bite?	☐ Yes ☐ No
Does food get caught in your teeth?	☐ Yes ☐ No

If yes, where?_____

Do you:

Clench or grind your teeth?	☐ Yes ☐ No
Bite your lips or cheeks regularly?	☐ Yes ☐ No
Hold foreign objects with your teeth? (i.e. pencils, pipes, pins, nails, fingernails)	☐ Yes ☐ No
Breathe through mouth?	☐ Yes ☐ No
Have tired jaws, especially in the A.M?	☐ Yes ☐ No
Smoke/chew tobacco?	☐ 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?	☐ Yes ☐ No

If so please describe, including cause:

_____

Have you noticed or experienced:

Clicking or popping of the jaw?	☐ Yes ☐ No
Pain? (joint, ear, side of face?	☐ Yes ☐ No
Difficulty in opening or closing mouth?	☐ Yes ☐ No
Headaches or shoulder aches?	☐ Yes ☐ No
Sore muscles?	☐ Yes ☐ No

Satisfied with your teeth's appearance?	☐ Yes ☐ No
Is keeping all of your teeth important?	☐ Yes ☐ No
Do you feel nervous about treatment?	☐ Yes ☐ No

If so, what is your biggest concern?_____

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

If yes, describe:_____

_____

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

If yes, please describe:_____

_____