Kingsland Family Dental Assoc.
Dental History

Patient Name:____DOB: ______________

What is the reason for your visit today? ____

Date of last dental visit ____________Last dental cleaning____________Last full mouth X-rays____________

What was done at your last dental visit?____

Previous Dentist's Name:____

Address:____

Street City State Zip

How often do you have dental exams/cleanings? 3months 4months 6months other:____________

How often do you brush? ____________________How often do you floss? ____________________

What other dental aids do you use? Waterpik Electric toothbrush Other: ____________

Do you have any dental problems now? Yes No If yes, please list: ____________________

Are any of you teeth sensitive to?

Yes No Hot or cold

Yes No Sweets

Yes No Biting or Chewing

Yes No Have you noticed any mouth odors or bad taste

Yes No Do you frequently get cold sores, blisters or any other lesions

Have you ever had?

Yes No Orthodontic treatment

Yes No Oral surgery

Yes No Periodontal treatment

Yes No Bite Adjustment

Yes No A bite plate or mouth guard

Yes No A serious injury to the mouth or head

Have you ever experienced?

Yes No Clicking or popping of the jaw

Yes No Pain (joint, ear side of face)

Yes No Difficulty in opening or closing the mouth

Yes No Difficulty in chewing on either side of the mouth

Yes No Headaches, neck aches or shoulder aches

Yes No Are you satisfied with your teeth's appearance

Yes No Would you like to keep all of your teeth for the rest of your life

Do you?

Yes No Clench or grind your teeth while awake or asleep

Yes No Bite your lip or cheeks regularly

Yes No Mouth breathe while awake or asleep

Yes No Hold foreign objects with teeth (pens, pencils or fingernails)

Yes No Have tired jaws, especially in the morning

Yes No Snore or have any other sleeping disorders

Yes No Do your gums bleed or hurt

Yes No Have your parents experienced gum disease or tooth loss

Yes No Have you ever noticed any loose teeth or change in your bite

Yes No Smoke/Chew tobacco or use other tobacco products

Yes No Do you use alcoholic beverages? How much? ____________How long? ____________

How would you rate you smile? Worst 1 2 3 4 5 6 7 8 9 10 Best

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

If yes, please explain: ____

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