Hilliard Advanced Dentistry
Healthy Smiles for a Lifetime

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Dental History

Welcome! All the information you share with us confidential.

Patient Information

Patient Name:_____ Date_____
Last First M.I. (Preferred Name)

A. Reason for Your Visit:

Do you haveany other dental problems now? If yes, please describe: _____

B. Your dental History:

Date of your last dental treatment:_____ Last Cleaning:_____ Last full mouth x/rays: _____

Previous Dentist's Name: _____

Address:_____State _____Zip_____

Telephone: (_____)_____

How often have you had dental examination in the past? _____

C. Your Gums:

Do your gums bleed?	[ ] No	[ ] Yes	How often? _____
Do you have any bad odors or tastes?	[ ] No	[ ] Yes	Where? _____
Have you had gum treatment?	[ ] No	[ ] Yes	What type? _____
Have your parents had gum disease?	[ ] No	[ ] Yes	Which parent? _____
Have your parents experienced tooth loss?	[ ] No	[ ] Yes	Which parent? _____
Do you smoke or chew tobacco?	[ ] No	[ ] Yes	Which one? _____

D. Your Teeth:

Are you sensitive to hot or cold?	[ ] No	[ ] Yes	Where? _____
Are you sensitive to sweets?	[ ] No	[ ] Yes	Where? _____
Are you sensitive to biting/chewing?	[ ] No	[ ] Yes	Where? _____
Does food get caught between your teeth?	[ ] No	[ ] Yes	Where? _____
Have you had oral surgery or extractions?	[ ] No	[ ] Yes	Which type? _____

D. Your Teeth:

Do you grind your teeth while you sleep?	[ ] No	[ ] Yes	Comments?_____
Do you have a clicking or popping jaw?	[ ] No	[ ] Yes	When? _____
Do you have pain in ear, joint or face?	[ ] No	[ ] Yes	When? _____
Do you have aches in neck and shoulder?	[ ] No	[ ] Yes	Where? _____
Do you have sore or tired jaws?	[ ] No	[ ] Yes	How often? _____
Do you get frequent headaches?	[ ] No	[ ] Yes	How often? _____
Have you had braces before?	[ ] No	[ ] Yes	When? _____
Have you had head or neck trauma before?	[ ] No	[ ] Yes	When? _____
Have you had night guards or bite guards?	[ ] No	[ ] Yes	What kind?_____

E. Your Appearance:

Are you satisfied with the appearance of your teeth? If not, please describe._____

_____

Additional Comments:

Is there anything else about having dental treatment that you want us to know? _____

_____

_____

G. Other:

Have you had an upsetting dental experience in the past? If yes, please describe._____

_____