NEAL FAMILY DENTAL

Dental History

Date:_____

Last Name_____**First**_____**MI**____**Birthdate:**_____

1) Your Impression of Your Overall Dental Health: □ **Excellent** □ **Good** □ **Fair** □ **Poor**

2) Have you ever required antibiotics prior to dental treatment ? □**Y** □**N** **Reason?**_____

3) Month/Year of last dental cleaning:_____**Name of previous dentist**_____
Reason for leaving last dental office: _____

4) Are you currently in pain? □**Y** □**N** **If Yes, Where?** _____

5) Pain level on a scale of 0 to 10 (10 being most painful): ____**/10**

6) Are your teeth sensitive to: heat, cold, sweets, pressure from biting, or chewing? □**Y** □**N** **Where?**_____

7) Do you have frequent cold sores, canker sores, fever blisters on gums, cheek, lips? □**Y** □**N** **Where?**_____

8) Have you ever had a serious/difficult problem with any previous dental work? □**Y** □**N Explain:**_____
_____

9) Home care: How often do you brush per day? 1 2 3x's per day. Toothbrush type: Manual or Electric?
Bristle type: Hard Medium Soft | **Do you use Water-Pik?** □**Y** □**N** | **Dental Floss** □**Y** □**N** | **Use Mouth Rinse?** □**Y** □**N**

10) Do you ever have food catch between your teeth? □**Y** □**N** **Difficulty Flossing?** □**Y** □**N** **Tight contacts?** □**Y** □**N**

11) Have you been informed or treated for the following dental conditions? (Check all that apply)

Bad Taste/Odor in Mouth	Gum: infections/Soreness/Bleeding	Thin enamel/Amelogenesis
Braces (Orthodontics)	Mobility of Teeth	Imperfecta
Deep Cleanings/Scaling	Oral Cancer	Tooth Brush Abrasion
Dry Mouth/Sjorgren's	Osseous Surgery	Wisdom Teeth

12) Do you have, or have you ever had, any of the following?

Clenching during day or night	□Y □N	Grinding/Clenching teeth	□Y □N
Clicking/Popping of Jaw Joint (TMJ)	□Y □N	Pain or ringing in your ears	□Y □N
Chronic neck-aches/Headaches	□Y □N	Jaw muscles tired, stiff, painful	□Y □N
Difficulty opening/closing jaw	□Y □N	TMD/TMJ Joint (Jaw) Pain	□Y □N

13) Have you ever had Obstructive Sleep Apnea (OSA)? □**Y** □**N** **Do you feel tired throughout the day?** □**Y** □**N**
Do you snore loud enough to be heard in another room? □**Y** □**N** **Has anyone observed that you stop breathing while you sleep?** □**Y** □**N**

14) Is there anything you would like to improve about your smile?_____
_____ **Are you interested in: Whiter Teeth?** □**Y** □**N** **Straighter Teeth?** □**Y** □**N**

15) What is most important to you about dental treatment? (Prioritize from 1 to 5, 5 being the most important)
_____**Comfort** _____**Appearance** _____**Time** _____**Long-term Care** _____**Immediate Emergency Care**

16) What can we do to make your dental experience more pleasant?_____

PATIENT SIGNATURE X_____**DATE:**_____
DENTAL SIGNATURE X_____**DATE:**_____
Reviewer/date_____ **Reviewer/date**_____ **Reviewer/date**_____ **Reviewer/date**_____ **Reviewer/date**_____