

Patient Name _____



DENTAL HISTORY

MICHAEL MORRISON, DDS
DENTISTRY BY DESIGN

Welcome! So that we may provide you with the best possible care.
Please fill this information form. All information is completely confidential.

How did you hear about our office? _____
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 _____ State _____ Zip _____
Telephone _____

Why did you leave your last dentist? _____
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? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? Yes No
If yes, please describe _____

Are any of your teeth sensitive to:			Have you ever had:		
Hot or cold?	Yes	No	Orthodontic treatment?	Yes	No
Sweets?	Yes	No	Oral surgery?	Yes	No
Biting or Chewing?	Yes	No	Periodontal treatment?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No	Your teeth ground or the bite adjusted?	Yes	No
Do you frequently get cold sores, blisters or any other oral lesions?	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 _____		
Do your gums bleed or hurt?	Yes	No			
Have your parents experienced gum disease or tooth loss?	Yes	No	Have you experienced:		
Have you noticed any loose teeth or change in your bite?	Yes	No	Clicking or popping of the jaw?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No	Pain? (joint, ear, side of face)	Yes	No
If yes, where? _____			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
			Sore muscles (neck, shoulders)?	Yes	No

Do you:			Do you feel nervous about having dental treatment?		
Clench or grind your teeth while awake or asleep?	Yes	No	Yes	No	
Bite your lips or cheeks regularly?	Yes	No	If so, what is your biggest concern? _____		
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	Yes	No	If there was a simple, inexpensive way to whiten your teeth, would you be interested?		
Mouth breath while awake or asleep?	Yes	No	Yes	No	
Have tired jaws, especially in the morning?	Yes	No	_____		
Smoke/chew tobacco?	Yes	No			

Are you satisfied with your teeth's appearance? Yes No
If not what would you change? _____

Is there anything else about having dental treatment that you would like us to know? Yes No
If yes, please describe _____

(Please complete other side)