

AllSmiles Dental Care PLLC

1043 Oaklawn Drive, Culpeper, VA 22701
540-829-9922

DENTAL HISTORY

Name: _____ Date: ____/____/____

Previous dentist's name: _____ Phone: (____) _____

Address: _____

Date of last dental visit: ____/____/____ Last cleaning: ____/____/____

What was the purpose of your last dental visit? _____

How often do you go to the dentist? _____ Last full mouth x-rays ____/____/____

How often do you brush your teeth? _____ How often do you floss? _____

What else do you use on your teeth/gums? (toothpick, tongue-scraper, etc.) _____

What dental problems are you having now? _____

Have you had:

Orthodontics	Y N	Teeth sensitive to hot or cold (circle)	
Oral surgery	Y N	Teeth sensitive to sweets	Y N
Periodontal treatment	Y N	Teeth hurt when biting or chewing	Y N
Bite adjustment	Y N	Bad taste in mouth or bad odor	Y N
Mouth guard	Y N	Frequent blisters, cold sores	Y N
Serious head/mouth injury	Y N	Bleeding and/or painful gums	Y N
describe _____			
Clicking or popping of jaw	Y N	Loose teeth or change in bite	Y N
Pain (joint, ear, side of face)	Y N	Food often getting caught between teeth	Y N
Problems opening or closing mouth	Y N	Where? _____	
Problems chewing on either side	Y N	Did your parents have gum disease or	
Aching in head, neck, shoulder	Y N	tooth loss?	Y N
Sore neck or shoulder muscles	Y N		

Do you

Grind /clench your teeth when awake/asleep (circle)			
Chew on your lips or cheeks often	Y N	Smoke/chew tobacco	Y N
Hold things with your teeth (pencils, nails, pins)	Y N	Snore or have a sleep disorder	Y N
Have sore teeth or tired jaws in the morning	Y N	Mouth breathe when awake or asleep	Y N

Do you want to keep all of your teeth for your entire life? Y N

Are you satisfied with the way your teeth look? Y N

If no, what would you like to change? _____

Are you nervous about receiving dental care? Y N

If yes, what concerns you the most? _____

If you have any other dental concerns or information you think we should have, please write it below.
