NOELCK & MA FAMILY
DENTISTRY

DENTAL HISTORY FORM

First Name: _____ Middle Initial: _____ Last Name: _____ DOB: _____

DENTAL HISTORY

What is your main dental concern today? _____

Are you currently experiencing any dental pain or discomfort? ☐ YES ☐ NO

How would you rate your oral health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist(s): _____ How long were you a patient? _____

Date of Last Dental Exam: _____ Date of Last X-Rays: _____

How often do you visit the dentist? EVERY: ☐ 3 Months ☐ 4 Months ☐ 6 Months ☐ 12 Months ☐ Not Routinely

Date of Last Dental Treatment (other than cleaning): _____

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

HISTORY QUESTIONS

#	QUESTION	YES	NO
1	Are you fearful of dental treatment? Anxiety level (1–10): ____	☐	☐
2	Have you had an unfavorable dental experience?	☐	☐
3	Have you experienced complications from dental treatment?	☐	☐
4	Have you had difficulty getting numb or reactions to anesthetic?	☐	☐
5	Have you had braces, orthodontic treatment, or a bite adjustment?	☐	☐
6	Have you had teeth removed?	☐	☐
7	Do your gums bleed or hurt when brushing or flossing?	☐	☐
8	Have you been treated for gum disease or bone loss?	☐	☐
9	Do you notice unpleasant taste or odor in your mouth?	☐	☐

10	Is there a family history of gum disease?	☐	☐
11	Have you experienced gum recession?	☐	☐
12	Have any teeth become loose without injury?	☐	☐
13	Have you experienced a burning sensation in your mouth?	☐	☐
14	Have you had cavities within the past 3 years?	☐	☐
15	Do you experience dry mouth or difficulty swallowing?	☐	☐
16	Do you notice pits or holes on biting surfaces of teeth?	☐	☐
17	Are your teeth sensitive to hot, cold, sweets, or biting?	☐	☐
18	Do you have grooves or notches near the gumline?	☐	☐
19	Have you broken, chipped, or cracked teeth or fillings?	☐	☐
20	Does food frequently get caught between your teeth?	☐	☐
21	Do you have jaw pain, popping, locking, or limited opening?	☐	☐
22	Does your bite feel like your jaw is pushed backward?	☐	☐
23	Do you avoid hard or chewy foods due to discomfort?	☐	☐
24	Have your teeth become shorter, thinner, or worn?	☐	☐
25	Have your teeth become more crowded or crooked?	☐	☐
26	Have your teeth developed spaces or loosened?	☐	☐
27	Do you shift your jaw to make your teeth fit together?	☐	☐
28	Do you rest your tongue between your teeth?	☐	☐
29	Do you chew ice, bite nails, or have oral habits?	☐	☐
30	Do you clench or grind your teeth during the day?	☐	☐
31	Do you have sleep issues, morning headaches, or jaw soreness?	☐	☐
32	Have you worn a bite appliance/night guard?	☐	☐
33	Would you like to change the appearance of your teeth?	☐	☐
34	Have you whitened your teeth before?	☐	☐
35	Have you felt self-conscious about your teeth?	☐	☐
36	Have you been unhappy with previous dental work?	☐	☐

ACKNOWLEDGEMENT

I certify that the above information is accurate to the best of my knowledge. I understand that providing incorrect information may affect my treatment or insurance processing.

Patient/Responsible Party Signature: _____ Date: _____