Alyce O'Brien, D.D.S. & Jack Batjer, D.D.S.

Dental History

please circle:

YES NO 1) Are you in dental discomfort today? If yes, please explain: ______

2) How long has it been since your last dental treatment? ______

3) What was done at that time? ______

4) When were x-rays last taken? ______

YES NO 5) Are you apprehensive about dental treatment? If yes, what do you need to be more comfortable or relaxed during dental visits? (i.e., nitrous oxide, headphones)

______

YES NO 6) Have you ever had any serious trouble associated with any previous dental treatment

If yes, please explain: ______

YES NO 7) Do you clench or grind your teeth?

YES NO 8) Have you ever had an unfavorable reaction to dental anesthetic? If yes, please explain:

______

YES NO 9) Do you gag easily?

YES NO 10) Do you floss regularly?

YES NO 11) Do your gums bleed?

YES NO 12) Have you ever experienced pain or discomfort in your jaw joint (TMJ/TMD)?

YES NO 13) Are teeth sensitive to: ☐ hot ☐ cold ☐ sweets ☐ pressure ☐ brushing

YES NO 14) Do you use cigars/cigarettes, pipe or chewing tobacco? If yes, list type and amount:

______

YES NO 15) Have you seen a dental specialist or had any of the following treatment?

- ☐ Orthodontic (braces) ______
- ☐ Endodontic (root canal treatment) ______
- ☐ Periodontic (gum disease) ______
- ☐ Oral Surgeon (extractions) ______
- ☐ Other ______

16) What could you change, if anything, about the appearance of your teeth and smile?

- ☐ Color ______
- ☐ Shape ______
- ☐ Crowding ______
- ☐ Missing Teeth ______
- ☐ Other ______

Patient Signature (Parent or Guardian) ______ Date ______