

# Adult Dental History

Patient's Name: \_\_\_\_\_

Date: \_\_\_\_\_

## Dental History:

Name of Dentist: \_\_\_\_\_

Dentist Phone #: \_\_\_\_\_

Date of most recent dental examination by your dentist? Month: \_\_\_\_\_ Year: \_\_\_\_\_

Your current dental health is:  Good  Fair  Poor

Do you like your smile?  Yes  No Do your Gums ever bleed?  Yes  No

Do you have speech problems?  Yes  No

If yes, please explain: \_\_\_\_\_

Do you generally breathe through your mouth?  Yes  No

If yes, please circle: While Awake? While Asleep?

Do you have any missing or extra teeth?  Yes  No

If yes, please explain: \_\_\_\_\_

Have you ever had serious/difficult problems associated with any previous dental work?  Yes  No

If yes, please explain: \_\_\_\_\_

Do you currently plan to have any dental work completed?  Yes  No

If yes, please explain: \_\_\_\_\_

Please list any pertinent dental history: \_\_\_\_\_

## Orthodontic Survey:

What are the main concerns that you would like orthodontics to accomplish?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever been evaluated or had orthodontic treatment?  Yes  No If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Have you ever had an injury to any of the following?  Yes  No

If yes, please circle and explain: Mouth Teeth Chin

\_\_\_\_\_

Have you ever had any pain/tenderness in your jaw joints (TMJ/TMD)?  Yes  No If yes, please explain:

\_\_\_\_\_

\_\_\_\_\_

Is there any family history of (TMJ/TMD) symptoms?  Yes  No

If yes, please explain \_\_\_\_\_

\_\_\_\_\_

Do you notice if you clench/grind your teeth?  Yes  No

If yes, please circle: While Awake? While Asleep?

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the confidence, and it is my responsibility to inform this office of any changes to my dental status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_