Welcome to My Practice

So that we may provide you with the best possible care,
please complete both pages of this Medical/Dental History form.
All information is kept confidential in accordance with New Zealand Dental Council Policy on privacy.

What is the reason for your visit today? _____

Date of: **Last Dental Visit** _____ **Last Dental Cleaning** _____

Last Full Mouth Xrays _____

What was done at your last dental visit? _____

Previous Dentist's Name _____ **Telephone No** _____

Address _____

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, toothpicks, etc) _____

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

Have you ever had:
Orthodontic treatment? ☐
Oral Surgery? ☐
Peridontal treatment? ☐
Your teeth ground or bite adjusted? ☐
A plate or mouth guard? ☐
A serious injury to mouth or head? **Yes / No**

Are any of your teeth sensitive to:
Hot or Cold? ☐
Sweets? ☐
Biting or Chewing? ☐
Have you noticed any mouth odours or bad tastes? ☐
Do you frequently get cold sores, blisters or any other oral lesions? ☐

If Yes, please describe: _____

Do your gums bleed or hurt? **Yes / No**
Have your parents had gum disease or tooth loss? **Yes / No**
Have you noticed any loose teeth or change in your bite? **Yes / No**
Does food get caught between your teeth? **Yes / No**

Do you:

Clinch or grind your teeth? **Yes / No**
Bite your lips or cheeks regularly? **Yes / No**
Hold foreign objects in your teeth? **Yes / No**
Mouth breathe whilst awake or asleep? **Yes / No**
Have tired jaws, especially in the morning? **Yes / No**
Smoke or chew tobacco? **Yes / No**

Have you experienced:

Clicking or popping of the jaw? ☐
Pain? (Joint, ear, side of face) ☐
Difficulty opening or closing the mouth? ☐
Difficulty chewing on either side of the mouth? ☐
Head, neck or shoulder aches? ☐
Sore muscles? (neck, shoulders) ☐

Are you satisfied with your teeth's appearance? **Yes / No**
Would you like to keep all your teeth all your life? **Yes / No**
Do you feel nervous about treatment? **Yes / No**

If yes, what is your biggest concern? _____

Have you ever had an upsetting dental experience? **Yes / No**

If yes, please describe: _____

Is there anything else about having dental treatment that you would like us to know? **Yes / No**

If yes, please describe: _____