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 Council Policy on privacy.

What is the reason for your visit today?

_____

Dates of your last: Dental Visit_____ Dental Cleaning_____ Full Mouth X-rays_____

What was done at your last dental visit? _____

Previous Dentist Name _____ Tel #_____

Previous Dentist 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? (Inter plak, toothpicks, etc.) _____

Do you have any dental problems now? Yes / No

If yes, please describe_____

Have you ever had:

Orthodontic treatment?	Yes / No
Oral Surgery?	Yes / No
Periodontal treatment?	Yes / No
Your teeth ground or bite adjusted?	Yes / No
A plate or mouth guards?	Yes / No
A serious injury to mouth or head?	Yes / No

If yes, please describe:

_____

Are any of your teeth sensitive to:

Hot or cold?	Yes / No
Sweets?	Yes / No
Biting or Chewing?	Yes / No

Have you noticed any mouth odors or bad tastes? Yes / No

Do you frequently get cold sores, blisters or any other oral lesions? Yes / No

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:

Clench or grin 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 in the jaw?	Yes / No
Pain? (Joint, ear, side of face)	Yes / No
Difficulty opening or closing the mouth?	Yes / No
Head, neck, or shoulder aches?	Yes / No
Sore muscles? (neck, shoulders)	Yes / No

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: _____