William J. Bennett III, D.D.S & Associates

Print Name: _____

DENTAL HISTORY

What is the reason for your visit today?

_____

_____

Date of last dental visit: _____

Last Dental Cleaning: _____

Last Full Mouth X-rays: _____

What was done at your last dental visit?

_____

Previous Dentist's Name: _____

City: _____ State: _____

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 experienced gum disease or tooth loss?	☐ Yes	☐ No
Have you noticed any loose teeth or change in your bite?	☐ Yes	☐ No
Does food tend to become caught in between your teeth?	☐ Yes	☐ No

Do you:

Clench or grind your teeth while awake or asleep?	☐ Yes	☐ No
Bite your lips or cheeks regularly?	☐ Yes	☐ No
Hold foreign objects with your teeth? (pencils, pins, etc.)	☐ Yes	☐ No
Mouth breathe while awake or asleep?	☐ Yes	☐ No
Have tired jaws, especially in the morning?	☐ Yes	☐ No
Snore or have any other sleeping disorders?	☐ Yes	☐ No
Smoke/chew tobacco or use other tobacco products?	☐ Yes	☐ No

DENTAL HISTORY CONTINUED

Have you ever had:

Orthodontic Treatment?	☐ Yes	☐ No
Oral Surgery?	☐ Yes	☐ No
Periodontal treatment?	☐ Yes	☐ No
Your teeth ground or the bite adjusted?	☐ Yes	☐ No
A bite plate or mouth guard?	☐ Yes	☐ No
A serious injury to the mouth or head?	☐ Yes	☐ No

If so, please, describe, including cause:

_____

_____

Have you experienced:

Clicking or popping of the jaw?	☐ Yes	☐ No
Pain? (joint, ear, side of face)	☐ Yes	☐ No
Difficulty in opening or closing mouth?	☐ Yes	☐ No
Difficulty in chewing on either side of the mouth?	☐ Yes	☐ No
Headaches, neck aches or shoulder aches?	☐ Yes	☐ No
Sore muscles (neck, shoulders)?	☐ Yes	☐ No
Would you like to keep all your teeth all of your life?	☐ Yes	☐ No
Do you feel nervous about having dental treatment?	☐ Yes	☐ No

If so, what is your biggest concern?

_____

Have you ever had an upsetting dental experience?	☐ Yes	☐ No

If yes, please describe:

_____

_____

Are there any other problems or concerns about your dental health not listed above?	☐ Yes	☐ No

If yes, please describe:

_____

_____