hoag & DOTSCH
creating your ultimate smile

Dental History

Patient Name: _____Date: _____

Your answers to this questionnaire will help us to understand what is important to you, so that we may more effectively treat you with consideration for your specific needs and desires.

Are any of your teeth sensitive to:

Hot or cold?	Y	N
Biting or chewing?	Y	N
Sweets?	Y	N

Do you:

Clench or grind your teeth while awake or asleep?	Y	N
Have bleeding gums or pain in the gum area?	Y	N
Have any family members experienced gum disease or tooth loss?	Y	N
Notice any loose teeth or a change in your bite?	Y	N
Get food caught between your teeth?	Y	N
Bite your lips or cheeks regularly?	Y	N
Mouth breathe while awake or asleep?	Y	N
Have a tired or sore jaw, especially in the morning?	Y	N
Smoke or chew tobacco?	Y	N
Do you frequently get cold sores, blisters or any oral lesions?	Y	N

Have you experienced:

Mouth odors or bad tastes?	Y	N
Popping of the jaw?	Y	N
Difficulty opening and closing your mouth?	Y	N
Frequent headaches or neck pain?	Y	N

Have you ever had:

Braces?	Y	N
Teeth removed?	Y	N
Gum treatment?	Y	N
Your bite adjusted?	Y	N
A mouth or night guard?	Y	N
A serious injury to your mouth, neck or head?	Y	N

How often do you:

Brush your teeth?

_____

Floss your teeth?

_____

What other dental aids do you use? (Sonicare, Waterpik, toothpicks, etc.)

_____

Have you ever had a less than positive dental experience?	Y	N
If you could safely whiten your teeth, would you be interested?	Y	N
Are you interested in saving your natural teeth?	Y	N
If yes, do we have your permission to inform you of any procedures that may be indicated to help you achieve your goal?	Y	N