LAUREL LASER DENTISTRY
tomorrow's dentistry today

DENTAL HISTORY

So that we may provide you with the best possible care, please complete this form as completely as possible.

Patient Name: _____ Medical Alert: _____

What is the reason for today's visit? _____

_____

Date of last dental visit _____ Reason _____

Date of last cleaning _____ Date of last x-rays _____

Previous dentist's name _____

Address _____

City / State / Zip _____ Phone _____

How often do you have dental check-ups? _____

How often do you brush? _____ floss? _____

What dental aids do you use? _____

What dental problems do you have now? _____

_____

Are any of your teeth sensitive to: (please check)

hot or cold? Yes No
sweets? Yes No
biting or chewing? Yes No
Do you get cold sores or other oral lesions? Yes No

Do you notice mouth odors or bad tastes? Yes No
Do your gums bleed or hurt? Yes No
Do you notice any loose teeth or change in your bite? Yes No
Does food tend to get caught in your teeth? Yes No
Do you smoke or chew tobacco? Yes No

Do you clench or grind while awake or asleep? Yes No
Do you mouth breath while awake or asleep? Yes No
Have you noticed clicking or popping of the jaw? Yes No
Do you have difficulty opening or closing? Yes No
Do you have pain or difficulty chewing? Yes No
Do you have tired jaws, especially in the morning? Yes No

Are you satisfied with the appearance of your teeth? Yes No
Rate your smile (on a scale of one to ten) _____
Would you like to keep all of your teeth for life? Yes No

Have you ever had:

Orthodontic Treatment? Yes No
Oral Surgery? Yes No
Periodontal Treatment? Yes No
A bite plate or mouth guard? Yes No
A serious injury to the mouth or head? Yes No
Your teeth ground or bit adjusted? Yes No
Pain in jaw, joint, ear or side of face? Yes No

Do you feel nervous about today's treatment? _____
What is your biggest concern? _____
What did you like best at your last dental office? _____

_____

What did you like least? _____
Have you ever had an upsetting dental experience? Yes No
If so, what was it? _____

_____

Is there anything else we should know? Yes No

_____

_____

Please rank the following in the order in which they would KEEP YOU from having treatment:

Fear of pain ____ Cost of treatment ____ Lack of concern ____
Missing time from work ____ Embarassed by current condition ____