David J. Shock, D.D.S.

Dental History Form

Patient Name: _____ Date: _____

What is the reason for your visit today?

Date of Last Dental Visit:	Date of Last Dental Cleaning:	Date of Last FMX/BWX:

1. Do you have any dental concerns at this time? Yes No
   If so, please describe_____
2. How often do you have dental examinations?_____
3. Have you ever had:
   a. Orthodontic treatment Yes No
   b. Oral surgery Yes No
   c. Periodontal treatment Yes No
   d. Your bite adjusted Yes No
   e. A mouth guard Yes No
   f. A serious injury to the mouth or head Yes No
      If yes, please describe _____
4. TMJ - Have you ever experienced:
   a. Clicking of the jaw? Yes No
   b. Difficulty in opening or closing? Yes No
   c. Difficulty in chewing? Yes No
5. Habits - Do you:
   a. Clench or grind your teeth? Yes No
   b. Bite your lips or cheeks regularly? Yes No
   c. Hold foreign objects with your teeth (pencils, pipes, pins, nails, fingernails)? Yes No
   d. Have tired jaws, especially in the morning? Yes No
   e. How often do you: Brush_____ Floss_____
   f. What other dental aids do you use? _____
6. Does food get caught between any of your teeth? Yes No
7. Do you suffer from bleeding or swelling in your gums? Yes No
8. Are you dissatisfied with the appearance of your teeth? Yes No
9. On a scale of 1-10 how would you rate your teeth? _____
10. Do you feel nervous about dental treatment? Yes No
    If so, what is your biggest concern? _____
11. Have you ever had an upsetting dental experience? Yes No
    If so, please describe _____
12. Are you interested in (circle any or all):
    a. Implants (permanently replacing missing teeth)?
    b. Orthodontics (straightening your teeth)?
    c. Whitening your teeth?
    d. Botox for TMJ or aesthetics?

Is there anything else about having dental treatment that you would like us to know?

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