Essential
Dental Hygiene Services

Name _____ **D.O.B.** ___/___/____
DAY MONTH YEAR

Medical Alert _____ ***Pre-Medicate***_____

Essential Dental Hygiene Services
CLIENT DENTAL HISTORY FORM

Reason for Initial Visit:_____
Last Dental Visit Date:_____
Last Dental Cleaning Date:_____
Last Full Mouth Series X-Rays Date:_____

Do you wear a denture? ..... No__ Yes__
complete- upper _____ lower_____
partial - upper_____lower_____
Are you suffering from pain now? ..... Yes__ No__
Are any of your teeth becoming loose? Yes__No__
Have any of your teeth shifted?..... Yes__ No__
Does food get caught between your teeth?.....Yes __ No__
Is there any swelling or pain of your gums? ..... Yes __ No__
Do you notice any bleeding from your gums when you brush your teeth? .....Yes __ No__
Is there any history of gum disease in your family?..... .....Yes____ No___

Treatments
Please check off the following treatments you have had:
A) Orthodontic Treatment?.....Yes__ No__
B) Oral Surgery?..... Yes__ No__
C) Peridontal treatment (gum surgery)?.....Yes__No____
D) Teeth ground or bite adjusted?..... Yes__ No___
E) Worn a bite plate or other appliance?.....Yes__No___
F) Dental implants?.....Yes __No__

Oral Hygiene
How often do you brush your teeth?_____
Floss your teeth? _____
Do you use any other devices to clean your teeth? (toothpicks, interdental brushes)..... Yes__ No__
Does your mouth tend to get dry?.....Yes__ No__
Are you aware of bad breath or a bad taste in your mouth?.....Yes __ No__
Are you aware of any sores or growths in your mouth?.....Yes__ No_

Habits
Do You:
Clench or grind your teeth while you are awake or asleep?..... Yes__ No__
Bite your lips or cheeks regularly?..... Yes__ No__
Hold foreign objects with your teeth (such as pencils, pipe, pins, nails, fingernails)?.....Yes__ No__
Breath through your mouth while awake or asleep?.....Yes __ No__

Consent to Treatment
I certify that I have read, understood and accurately completed the personal medical and dental histories to the best of my knowledge and have not knowingly omitted any information. This information has been reviewed with me, and I have had the chance to ask questions and to receive answers regarding any medical and dental histories. As may be required, I consent to my physician being contacted regarding any specific medical question. I authorize the Dental Hygienist to perform necessary diagnostic procedures and treatment as required to achieve the proper level of oral hygiene. I understand that I am financially responsible for the dental hygiene services provided even if my insurance coverage may not be inclusive.

Signature: _____ Date:_____