Dr. Thomas Gibbs
Dental History

Patient Name: ______________________________________ Date: __________________________

What is the reason for today's visit? ____

Date of last dental visit ________________________ Reason _____________________________________

Date of last cleaning ________________________________Last x-rays ____________________________

Previous dentist's name ____

Address ____

How often do you have dental check-ups? ____

How often do you brush? _____________________________ Floss?____________________________________

What dental aides do you use? ____

What dental problems do you have now? ____

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

Hot or cold? YES NO

Sweets? YES NO

Biting or chewing? YES NO

Do you get cold sores or lesions? YES NO

Do you notice mouth odors or bad tastes? YES NO

Do your gums bleed or hurt? YES NO

Any loose teeth or change in your bite? YES NO

Does food tend to get caught anywhere? YES NO

Do you smoke/chew tobacco? YES NO

Do you clench or grind your teeth? YES NO

Do you mouth breathe while awake/asleep? YES NO

Have you noticed clicks 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

Are your jaws tired in the morning? YES NO

I'm happy with the appearance of my teeth. YES NO

Rate your smile (on a scale of 1 to 10) _____________

Do you want 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 bite adjusted? YES NO

Pain in jaw, joint, ear or side of face? YES NO

Do you feel nervous about today's visit? YES NO

What is your biggest concern? _______________________

What did you like best about your last dental office?______

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What did you like least?__________________________

Have you had an upsetting dental experience? YES NO

If so, what was it?______________________________

Is there anything else we should know?________________

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Please rank the following in the order they would KEEP you from having dental work:

1.Fear of pain ___________________________

2. Cost of Treatment ______________________

3. Missing time from work _________________

4. Embarrassed by dental condition ___________