

Joseph B. Silberman, DMD, FAGD

Welcome! So that we may provide you with the best possible care, please complete the entire dental history form. All information will be kept completely confidential.

Today's Date _____

Purpose of your visit today _____

Previous Dentist's Name _____

Address _____ City _____ State _____ Zip _____

Phone _____

Date of Last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____

How often do you brush your teeth? _____ How often do you floss? _____

Are any of your teeth sensitive to: (check all that apply) Hot Cold Sweets Biting Chewing
 If yes, where? _____

Have you noticed any mouth odors or bad tastes? Yes No

Do you ever get cold sores, blisters or any other mouth/lip lesions? Yes No

Have you noticed any loose teeth or a change in your bite? Yes No

Does food tend to get caught in between your teeth? Yes No

Do you:

Clench or grind your teeth?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Smoke/chew tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have tired jaws (esp. in the morning)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Breathe through your mouth?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Frequently bite your lips or cheeks?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hold foreign objects in your teeth?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Have you experienced:

Clicking/popping of the jaw?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty opening/closing your mouth?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Difficulty chewing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches, neck pain or shoulder pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Have you ever had:

Orthodontic treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Oral Surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Periodontal (Gum) treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Your teeth ground or your bite adjusted?	<input type="checkbox"/> Yes <input type="checkbox"/> No
A bite plate or mouth guard?	<input type="checkbox"/> Yes <input type="checkbox"/> No	A serious injury to your mouth or head?	<input type="checkbox"/> Yes <input type="checkbox"/> No

If yes, please describe _____

Are you satisfied with the appearance of your teeth? Yes No If no, please describe _____

Do you feel nervous about having dental treatment? Yes No If yes, what is your biggest concern?

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