CUPERTINO DENTAL GROUP

New Patient Dental History

Welcome to Cupertino Dental Group. To help us ensure the highest quality of care, please complete this questionnaire.

Patient's Full Name: _____ Date: _____

What is the reason for your visit today? _____

_____

Your current dental health is: ◯ **Good** ◯ **Fair** ◯ **Poor**

Do you require antibiotics before dental treatment? ◯ **Yes** ◯ **No**

Date of last dental visit: _____ Last dental cleaning: _____ Last full mouth x-rays: _____

What was done at your last dental visit? _____

_____

Why did you leave your previous dentist *(optional)*? _____

Name of previous dentist: _____ Prev. dentist's telephone#: _____

How often do you have dental cleanings? _____ How often do you brush your teeth? _____ How often do you floss? _____

What, if any, other dental aids do you use (i.e. – waterpik, electric toothbrush, etc.)? _____

Do you have any dental problems at this time? ☑ **Yes** ☑ **No** If yes, please explain: _____

_____

_____

Do you now or have you ever had any pain/discomfort in your jaw joint (TMJ)? ◯ **Yes** ◯ **No**

Do you clench or grind your teeth? ◯ **Yes** ◯ **No**

Do you have frequent "tension" headaches? ◯ **Yes** ◯ **No**

Do you hold or chew objects with your teeth (pencils, fingernails, etc.)? ◯ **Yes** ◯ **No**

Do you mouth breathe while awake or asleep? ◯ **Yes** ◯ **No**

Do you have sleep apnea? ◯ **Yes** ◯ **No** If yes, how are you managing it? _____

Are you missing any teeth? ◯ **Yes** ◯ **No** Have they been replaced? ◯ **Yes** ◯ **No**

Do your gums bleed when you floss or brush your teeth? ◯ **Yes** ◯ **No**

Have you ever been treated by a periodontist (gum specialist)? ◯ **Yes** ◯ **No** If yes, please explain: _____

_____

Have you ever had orthodontic treatment? ◯ **Yes** ◯ **No** If yes, when and by whom? _____

_____

Have you ever had dental implants? ◯ **Yes** ◯ **No** If yes, when and by whom? _____

_____

Have you ever had a serious injury to the mouth or face? ◯ **Yes** ◯ **No** If yes, please explain: _____

_____

Are any of your teeth sensitive to: ◯ **Hot** ◯ **Cold** ◯ **Sweets** ◯ **Pressure** Please explain: _____

_____

Are you happy with the color of your teeth? ◯ **Yes** ◯ **No**

Is there anything you would like to change about your smile? ◯ **Yes** ◯ **No** If yes, please explain: _____

_____

Have you ever had any serious issues/difficulties with previous dental treatment? _____

_____

Have you ever had any unfavorable dental treatment related experiences? ◯ **Yes** ◯ **No** If yes, please explain: _____

_____

Is there anything else you would like us to know about your dental health or previous dental treatment? _____

_____

_____

_____