Jeffrey D. Hamilton, DDS, PS
Cosmetic & Family Dentistry

1800 Cooper Point Rd SW #23
Olympia, WA 98502
P: (360) 352-1330 **F:** (360) 357-8452
info@jeffreydhamiltondds.com
jeffreydhamiltondds.com
facebook.com/jeffhamiltonDDS

DENTAL HISTORY

Patient's Name _____ Person Completing Form _____

Medical Alert _____

What is the reason for your visit today? _____

_____

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

What was done at your last dental visit? _____

_____

Previous dentist's name _____ Address _____ Phone # _____

How often do you have dental examinations? _____

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

Have you ever used or are you currently using topical fluoride? ☐Yes ☐No

What other dental aids do you use? (Interplak, toothpick, etc...) _____

Do you have dental problems now? ☐Yes ☐No

If yes, please describe _____

_____

Please answer the following:

Sensitivity to hot or cold?..... ☐Yes ☐No
Sensitivity to Sweets?..... ☐Yes ☐No
Sensitivity to Biting or chewing?..... ☐Yes ☐No
Have you noticed any mouth odors or bad taste?..... ☐Yes ☐No
Do you frequently get cold sores, blisters or any other lesions? ☐Yes ☐No
Do your gums bleed or hurt?..... ☐Yes ☐No
Have your parents experienced gum disease or tooth loss?..... ☐Yes ☐No
Have you noticed any loose teeth or change in your bite?..... ☐Yes ☐No
Does food tend to become caught in between your teeth?..... ☐Yes ☐No
If yes, where?

_____

_____

Do you:

Clench or grind your teeth while awake or asleep?..... ☐Yes ☐No
Bit your lips or cheeks regularly?..... ☐Yes ☐No
Hold foreign objects with your teeth?..... ☐Yes ☐No
(pencils, pipe, pins, nails, fingernails)
Mouth breathe while awake or asleep?..... ☐Yes ☐No
Have tired jaws, especially in the morning?..... ☐Yes ☐No
Snore or have any other sleeping disorders?..... ☐Yes ☐No
Smoke / chew tobacco or use other tobacco products?..... ☐Yes ☐No
Do you regularly drink soda, energy or sports drinks?..... ☐Yes ☐No

Have you ever had:

Orthodontic treatment?..... ☐Yes ☐No
Oral Surgery?..... ☐Yes ☐No
Periodontal treatment?..... ☐Yes ☐No
Your teeth ground or the bite adjusted?..... ☐Yes ☐No
A bite plate or mouth guard?..... ☐Yes ☐No
A serious injury to the mouth or head?..... ☐Yes ☐No
If so, please describe, including cause

_____

Have you experienced:

Clicking or popping of the jaw?..... ☐Yes ☐No
Pain? (joint, ear, side of face)..... ☐Yes ☐No
Difficulty in opening or closing the mouth?..... ☐Yes ☐No
Difficulty in chewing on either side of the mouth?..... ☐Yes ☐No
Headaches, neck aches or shoulder aches?..... ☐Yes ☐No
Sore muscles (neck, shoulders)?..... ☐Yes ☐No

Are you satisfied with your teeth's appearance?

Would you like to keep all of your teeth all your life?..... ☐Yes ☐No
Do you feel nervous about having dental treatment?..... ☐Yes ☐No
If so, what is your biggest concern?

_____

Have you ever had an upsetting dental experience?..... ☐Yes ☐No
If so, what is your biggest concern?

_____

Have you ever been told to take a pre-medication prior to a dental treatment? ☐Yes ☐No
Is there anything else about having dental treatment that you would like us to know? ☐Yes ☐No

If yes, please describe _____

_____