Cornerstone Dental of Green Brook
314 US HWY 22 West, Ste. D
Green Brook, NJ 08812

Patient Name: _____ **DENTAL HISTORY**

Welcome! Please complete this dental history form so that we may provide you with the best possible dental care.

What is the reason for your visit today? _____

_____

Date of Last Dental Visit? _____ Last Dental Cleaning _____ Last Full Mouth X-rays_____

What was done at your last dental visit? _____

Previous Dentist's Name _____ Telephone _____

Address _____ State _____ Zip _____

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

Have you ever used or are you currently using topical fluoride? (Please circle one) **YES or NO**

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

Do you have any dental problems now? If yes, please describe: _____

Please complete below by circling YES or NO.

Are any of your teeth sensitive to:

Hot or Cold? ..... **YES OR NO**
Sweets? ..... **YES OR NO**
Biting or chewing? ..... **YES OR NO**
Have you noticed mouth odors or bad taste?..... **YES OR NO**
Do you frequently get cold sores, blisters or any other oral lesion? .....**YES OR NO**
Do your gums bleed or hurt? ..... **YES OR NO**
Have you experienced gum disease or tooth loss? ..... **YES OR NO**
Have you noticed any loose teeth or change in your bite? ..... **YES OR NO**
Does food tend to become caught in between your teeth? ..... **YES OR NO**
If yes, where? _____

Do you:

Clench or grind your teeth? ..... **YES OR NO**
Bite your lips or cheeks regularly? ..... **YES OR NO**
Mouth breathe while awake or sleep? ..... **YES OR NO**
Have tired jaws, especially in the AM? ..... **YES OR NO**
Snore or have other sleeping disorders? ..... **YES OR NO**
Smoke/Chew tobacco or use other tobacco products? ..... **YES OR NO**

Have you ever had:

Orthodontic treatment? ..... **YES OR NO**
Oral Surgery? ..... **YES OR NO**
Periodontal Surgery?..... **YES OR NO**
A bite plate or mouth guard? ..... **YES OR NO**
A serious injury to the mouth or head? ..... **YES OR NO**
If yes, please describe: _____
_____

Have you experienced:

Clicking or popping of the jaw? ..... **YES OR NO**
Pain (joint, ear, side of face)? ..... **YES OR NO**
Difficulty in opening or closing the mouth?... **YES OR NO**
Difficulty in chewing on either side of the mouth? .....**YES OR NO**
Headaches, neck or shoulder aches? ..... **YES OR NO**
Are you satisfied with your teeth's appearance? ..... **YES OR NO**
Do you feel nervous about having dental treatment? .....**YES OR NO**
If so, what is your biggest concern? _____
_____
Have you ever had an upsetting dental experience?.....**YES OR NO**
If yes, please describe: _____

Have you ever been told to take a pre-medication prior to dental treatment? **YES OR NO**

Patient Signature _____ Date_____

Dentist Signature _____ Date _____