Dental History Form

Please bring a printed copy of this form fill out this form electronically or by hand to your appointment.
Thank you! - Your friends at Pine River Dental Arts

Patient Last Name :

Patient First Name :

Reason for Today's Visit :

Former Dentist :

Date of Last Dental Visit :

Date of Last Dental X-Rays :

Please check if you have/had :

Blisters on lips or mouth

☐ Yes ☐ No

Bad Breath

☐ Yes ☐ No

Burning Tongue

☐ Yes ☐ No

Cheek/Tongue Biting

☐ Yes ☐ No

Tobacco Use :

☐ Yes ☐ No

Dry Mouth

☐ Yes ☐ No

Snoring/Sleep Apnea

☐ Yes ☐ No

Head/Neck/Jaw Pain

☐ Yes ☐ No

Mouth Breathing

☐ Yes ☐ No

Swollen/Bleeding Gums

☐ Yes ☐ No

Periodontal Treatment

☐ Yes ☐ No

Oral Surgery

☐ Yes ☐ No

Orthodontic Treatment

☐ Yes ☐ No

Nitrous Oxide

☐ Yes ☐ No

Clench/Grind Teeth

☐ Yes ☐ No

Tooth Sensitivity

☐ Yes ☐ No

Growths/Sore Spots in your mouth

☐ Yes ☐ No

Dental Anxiety

☐ Yes ☐ No

Have you ever had an allergic or negative reaction to Novocaine, local or general anesthetics?
If so please describe :

☐ Yes ☐ No

Is there anything you would like to change about your smile or appearance of your teeth?
If so please describe :

☐ Yes ☐ No