



CHRIS LEISZLER, DDS

FAMILY & COSMETIC DENTISTRY

DENTAL HISTORY QUESTIONNAIRE

Today's Date: _____ Name: _____ Date of Birth: _____

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- What is the reason for your visit today? ___ Checkup
 ___ Tooth ache
 ___ Teeth or gums hurting or bothering me
 ___ Other _____
-
- When was the last time you were seen by a dentist for a cleaning? _____
-
- When was the last time you were seen by a dentist for a complete dental exam? _____
-
- How often do you have dental examinations?
 ___ Twice per year ___ Once per year ___ Every few years ___ More than 3 years between exams
-
- How many times a day do you brush your teeth? _____
-
- How many times a day do you floss? _____
-
- What type of toothbrush do you use? ___ Manual ___ Electric ___ Both
-
- Do you wear removable dentures or partial dentures? ___ Yes ___ No
-
- If you wear dentures or partial dentures, when were they placed? _____
-
- Are you using any other dental devices (i.e. retainer, bite guard, snoring appliance, etc.)?
 ___ Yes ___ No
If yes, please describe: _____
-
- Do you have any dental problems now or feel pain to any of your teeth?
 ___ Yes ___ No
If yes, please describe: _____
-
- Are your teeth sensitive to any of the following: ___ Hot/Cold ___ Sweets ___ Biting/Chewing
-
- Do you have any sores or lumps in or near your mouth? ___ Yes ___ No
-
- Do your gums bleed while brushing or flossing? ___ Yes ___ No ___ Sometimes
-
- Does food tend to become caught in between your teeth? ___ Yes ___ No
-
- Do you clench or grind your teeth? ___ Yes ___ No ___ Unsure
-
- Do you bite your lips or cheeks frequently? ___ Yes ___ No
-
- Do you hold foreign objects with your teeth (pencils, pipes, nails, fingernails, etc.)? ___ Yes ___ No
-

DENTAL HISTORY QUESTIONNAIRE

Today's Date: _____ Name: _____ Date of Birth: _____

Do you have tired jaws, especially in the morning? ___ Yes ___ No

Do you smoke or use tobacco? ___ Yes ___ No

Have you ever had orthodontic treatment (i.e. braces, retainer, etc.)? ___ Yes ___ No

Have you ever had any of the following? (If yes, please describe.):

- ___ Oral Surgery _____
- ___ Periodontal Treatment _____
- ___ Your bite adjusted _____
- ___ A Night Guard _____
- ___ A serious injury to the mouth or head _____

Have you ever experienced any of the following?:

- ___ Clicking or popping of the jaw
- ___ Pain in joint, ear, side of face
- ___ Difficulty opening or closing the mouth
- ___ Difficulty chewing on either side of the mouth
- ___ Headaches, neckaches, or shoulder aches
- ___ Sore muscles (neck, shoulders)

Have you ever had difficult tooth extractions in the past? ___ Yes ___ No

Have you ever had prolonged bleeding following an extraction? ___ Yes ___ No

Are you interested in doing cosmetic treatment (i.e. teeth whitening, veneers, straightening teeth, changing your smile)? ___ Yes ___ No

Do you like your smile? ___ Yes ___ No

Is there anything else about having dental treatment that you would like us to know? (If yes, please describe.) ___ Yes ___ No

Comments: _____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such medical care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the doctor or doctor group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature: _____