



**all smiles.**  
 Bradley Westbrook, D.D.S. • Charlie Stocks, D.D.S.  
 allsmilesjacksonville.com

2110 East Rusk Street  
 Jacksonville, TX 75766  
 Phone 903.586.0741  
 Fax 903.586.0649

[www.allsmilesjacksonville.com](http://www.allsmilesjacksonville.com)

**DENTAL HISTORY**

Patient name \_\_\_\_\_ Referred by \_\_\_\_\_  
 Previous dentist \_\_\_\_\_ For how long? \_\_\_\_\_  
 Most recent dental exam \_\_\_\_\_ Most recent dental x-ray \_\_\_\_\_  
 Most recent dental treatment \_\_\_\_\_  
 How often do you have your teeth cleaned?    3 months    4 months    6 months    1 year or longer

**YOUR IMMEDIATE DENTAL CONCERN(S)?**

**PLEASE ANSWER YES OR NO TO THE FOLLOWING:**

|   |     |    |  |     |    |
|---|-----|----|--|-----|----|
| Unhappy with the appearance of your teeth?.....                             | YES | NO | Unpleasant taste or odor in your mouth? .....        | YES | NO |
| Unfavorable dental experiences?.....  | YES | NO | Dry mouth, throat, and or eyes?.....                 | YES | NO |
| Dental fears? .....   | YES | NO | Jaw problems (temporomandibular joint)? .....        | YES | NO |
| Problems with effectiveness or bad reactions<br>to dental anesthetic? ..... | YES | NO | Difficulty opening your mouth widely? .....          | YES | NO |
| Orthodontic treatment (braces)?.....  | YES | NO | Stiff neck muscles?.....                             | YES | NO |
| Periodontal (gum) treatment?.....   | YES | NO | Awaken with an awareness of your teeth or jaws?..... | YES | NO |
| Bleeding gums?.....   | YES | NO | Tension headaches?.....                              | YES | NO |
| Avoid brushing any part of your mouth?.....                                 | YES | NO | Clench or grind your teeth? .....                    | YES | NO |
| Part of your mouth sensitive to temperature?.....                           | YES | NO | Jaw clicking or popping? .....                       | YES | NO |
| Sore teeth? .....   | YES | NO | Lost any teeth? .....                                | YES | NO |
| Burning sensation in your mouth?.....                                       | YES | NO | Sweat or tremble alot during examination? .....      | YES | NO |
| Difficulty swallowing?.....   | YES | NO | Strange people or places make you afraid?.....       | YES | NO |

**SUPPLEMENTAL DENTURE HISTORY:**

**If you are wearing a partial or complete artificial denture, please complete the following:**

Has your present denture been relined? ..... YES NO  
 If yes, when (month/year)  
 Is your present denture a problem?..... YES NO  
 If yes, describe  
 Satisfied with the appearance? ..... YES NO  
 Satisfied with the comfort? ..... YES NO  
 Satisfied with the chewing ability?..... YES NO  
 When did you receive your first partial or complete denture?  
 How long have you worn your present denture?

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**NOTE: If remitting electronically via email or fax, patient will sign and date at first office visit.**