

Medical Alert

Serenity Dental
Ed S. Trizzino, D.D.S.
Northside Alpharetta Medical Campus
3400 Old Milton Parkway, Building C
Suite 370
Alpharetta, GA 30005



tel. 770.777.0808
fax 770.777.1113
email info@goaheadandsmile.com
web www.goaheadandsmile.com

Dental History

Welcome! So that we may provide you with the best possible care, please complete both sides of this dental/medical history form. All information is completely confidential.

Patient name: _____
Wish to be called: _____
Date of last dental visit (to any office): _____
Date of last dental cleaning: _____
Date of last full mouth x-rays: _____

Previous Dentist Info

Name: _____
Phone: _____
Address: _____
City: _____
State: _____
Zip: _____

How often do you brush your teeth? _____
What type of brush?: Soft Medium Hard
How often do you floss? _____
Would other dental aides do you use?
 Electric toothbrush
 Toothpick
 Fluoride rinse
 Other: _____

Have you received any formal oral hygiene instruction?
 Yes No If yes, how long ago? _____
Would you like to keep all your teeth for the rest of your life?
 Yes No

Have you ever had:

Orthodontic treatment Yes No
Endodontic treatment (root canals) Yes No
Oral surgery (extractions) Yes No
Periodontal treatment Yes No
Osseous surgery Yes No
Gingival grafts Yes No
Tissue management (scaling, Curettage) Yes No
Your gums hurt/bleed Yes No
Any mouth odor or bad taste Yes No
Any loose teeth Yes No
Change/shift in your bite Yes No
Food caught in between your teeth Yes No
If yes, where? Yes No
A serious injury to mouth or head? Yes No
If yes, please describe including the cause:

Do you:

Frequently get cold sores Yes No
Blisters or any other oral lesions Yes No
Clinch for grind your teeth while awake or asleep Yes No
Bite your lips or cheeks regularly Yes No
Hold foreign objects with your teeth Yes No
Mouth breath while awake or asleep Yes No
Smoke/chew tobacco Yes No
Wear a mouth plate or mouth guard Yes No

Have you experienced:

TMJ/TMD Temporal Mandibular Disorder Yes No
Occlusal equilibration/bite adjusted Yes No
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
Tired jaws, especially in the mornings Yes No
Frequent headaches Yes No
Sore neck and/or shoulder muscles Yes No
Excess stress or pressure at work or at home Yes No
If so, please describe:

Any of your teeth sensitive to:

Hot or cold Yes No
Sweets Yes No
Biting or chewing Yes No

What is the reason for your visit today?

Do you feel nervous about having dental treatment? Yes No If yes, explain:

Is there anything else about having dental treatment that you would like us to know?

How do you feel about the appearance of your teeth?

What do you wish could be changed about your teeth?
