Dental History

Patient's Name _____ Date of Birth_____

CIRCLE THE APPROPRIATE ANSWER, IF UNSURE, PLEASE WRITE "Don't Know" ON THE LINE PROVIDED
IF QUESTIONS ASKS "please list", PLEASE LIST ON BACK OF THIS PAGE

1. Purpose of initial visit _____
2. Are you aware of any problems ……Yes No
   If So, _____
3. How long since your last dental visit _____
4. What was done at this time _____
5. Previous dentist name _____ Phone # _____
6. When was the last time your teeth were cleaned _____
7. Have you made regular visit ……Yes No
   How often _____
8. Were dental x-rays taken ……Yes No
9. Have you lost any teeth or have any teeth removed ……Yes No
10. Have they been replaced……Yes No
11. How have they been replaced:
    a. Fixed Bridge _____ When _____
    b. Removable Bridge _____ When _____
    c. Denture _____ When _____
    d. Implant _____ When _____
12. Are you unhappy with the replacement ……Yes No
    If yes, explain _____
13. Would you like to know about permanent replacements ……Yes No
14. Have you have any problems or complications with prevous dental treatment ……Yes No
    If yes, explain _____
15. Do you clench or grind your teeth ……Yes No
16. Does your jaw click or pop ……Yes No
17. Have you experienced any pain or soreness in the muscles of your face or around the ear ……Yes No
18. Do you have frequent headaches, neckaches or shoulder aches ……Yes No
19. Does food get caught in your teeth ……Yes No
20. Are any of your teeth sensitive to ……□ Hot? □ Cold? □ Sweets? □ Pressure?
21. Do your gums bleed or hurt ……Yes No
22. How often do you brush your teeth _____When? _____
23. Do you use dental floss ……Yes No
    How Often _____
24. Are any of your teeth loose, tipped, shifted, or chipped ……Yes No
25. Are you unhappy with the appearance of your teeth ……Yes No
26. How do you feel about your teeth in general _____
27. Do you feel your breath is offensive at times ……Yes No
28. Have you had gum treatment or surgery ……Yes No
    What? _____
    When? _____
29. Have you had any orthodontic work (braces) ……Yes No
30. Have you had any unpleasant dental experiences or any dislikes toward dentistry ……Yes No
    If yes, explain _____
31. Do you have any questions or concerns……Yes No

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S/GUARDIAN
SIGNATURE_____DATE_____