

WELCOME

Patient's Name: _____ Date of Birth _____

1. Purpose of initial visit _____
2. Are you aware of any problems? _____
3. How long since your last dental visit? _____ What was done at that time? _____
4. Previous dentist's name _____ Telephone number _____
Address: _____
5. When was the last time your teeth were cleaned? _____

CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER, PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

6. Have you made regular visits to the dentist? YES NO
How often: _____
7. Were dental x-rays taken at your last appointment? YES NO
8. Have you lost any teeth or have any teeth been removed? YES NO
Why? _____ Have they been replaced? YES NO
9. How have they been replaced?
a. Fixed bridge _____ Age of bridge _____
b. Removable bridge _____ Age of bridge _____
c. Denture _____ Age of denture _____
d. Implant _____ Age of Implant _____
10. Are you unhappy with the replacement? YES NO
If yes, please explain: _____
11. Have you ever had any problems or complaints with previous dental treatment, or is there anything about dentistry that you strongly dislike? _____
12. Do you clinch or grind your teeth? YES NO
13. Does your jaw click or pop? YES NO
14. Have you experienced any pain or soreness in the muscles of your face or around your ear? YES NO
15. Do you have frequent headaches, neck aches or shoulder aches? YES NO
16. Does food get caught in your teeth? YES NO
17. Are any of your teeth sensitive to Hot? Cold? Sweets? Pressure?
18. Do your gums bleed or hurt? YES NO
When? _____
19. How often do you brush your teeth? _____ When? _____
20. Do you use dental floss? YES NO
How often? _____
21. Are any of your teeth loose, tipping, shifted or chipped? YES NO
22. Are you unhappy with the appearance of your teeth? YES NO
23. How do you feel about your teeth in general? _____
24. Do you feel your breath is offensive at times? YES NO
25. Have you ever had gum treatment or surgery? YES NO
What? _____ When? _____ Where? _____
26. Have you had any orthodontic work? YES NO
27. Do you have any questions or concerns? _____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

DENTAL HISTORY