

PATIENT'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

REASON FOR THIS VISIT \_\_\_\_\_

WHEN WAS YOUR LAST DENTAL VISIT \_\_\_\_\_ REASON \_\_\_\_\_

HOW OFTEN DID YOU ROUTINELY VISIT THE DENTIST \_\_\_\_\_

PREVIOUS DENTIST (NAME & LOCATION) \_\_\_\_\_

How Often Do You Brush \_\_\_\_\_ Floss \_\_\_\_\_ Mouthrinse \_\_\_\_\_

	YES	NO		YES	NO
Do your gums bleed while brushing/flossing	<input type="checkbox"/>	<input type="checkbox"/>	Do you bite your lips or cheeks	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to hot or cold liquids/foods	<input type="checkbox"/>	<input type="checkbox"/>	Do you have loose teeth	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to sweet or sour liquids/foods	<input type="checkbox"/>	<input type="checkbox"/>	Does food collect between your teeth	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel pain to any of your teeth	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had periodontal treatment (gums)	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any sores or lumps in or near your mouth	<input type="checkbox"/>	<input type="checkbox"/>	Ever worn a bite plate or other appliance	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any head, neck or jaw injuries	<input type="checkbox"/>	<input type="checkbox"/>	Have you had your wisdom teeth extracted	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever experienced any of the following problems in your jaw?			Have you ever had any prolonged bleeding following extractions	<input type="checkbox"/>	<input type="checkbox"/>
Clicking, Pain	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear dentures or partials		
Difficulty in opening or closing	<input type="checkbox"/>	<input type="checkbox"/>	If yes, date of replacement _____		
Have you ever received oral hygiene instructions	<input type="checkbox"/>	<input type="checkbox"/>	Do you have frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>
Do you snore?	<input type="checkbox"/>	<input type="checkbox"/>	Do you clench or grind your teeth	<input type="checkbox"/>	<input type="checkbox"/>
Do you or have you used a CPAP machine	<input type="checkbox"/>	<input type="checkbox"/>			

	YES	NO		YES	NO
Do you like the general appearance of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Are you happy with the appearance of your teeth in the back?	<input type="checkbox"/>	<input type="checkbox"/>
Their color?	<input type="checkbox"/>	<input type="checkbox"/>	Are you happy with your crowns/bridges/partial/dentures?	<input type="checkbox"/>	<input type="checkbox"/>
Spacing?	<input type="checkbox"/>	<input type="checkbox"/>	Are you happy with other cosmetic dentistry you have had?	<input type="checkbox"/>	<input type="checkbox"/>
Straightness?	<input type="checkbox"/>	<input type="checkbox"/>			
Size?	<input type="checkbox"/>	<input type="checkbox"/>			
Have you ever worn braces?	<input type="checkbox"/>	<input type="checkbox"/>			
Are you happy with the freshness of your breath?	<input type="checkbox"/>	<input type="checkbox"/>			
If you could change anything about your smile, what would you change?	_____				

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.

\_\_\_\_\_  
SIGNATURE OF PATIENT OR PARENT IF MINOR

\_\_\_\_\_  
DATE

**DOCTOR'S COMMENTS:** \_\_\_\_\_

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

PATIENT'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

## PATIENT DENTAL HISTORY