DENTAL HISTORY-ADULT

NAME:_____
Last First M.I.

1. PURPOSE OF YOUR VISIT_____

2. ARE YOU AWARE OF A PROBLEM____Y ____N EXPLAIN _____

3. HOW LONG SINCE YOUR LAST DENTAL VISIT_____WHAT WAS DONE AT THAT VISIT _____

4. WHAT WAS YOUR PREVIOUS DENTISTS NAME/PHONE_____

5. WHEN WERE YOUR TEETH LAST CLEANED_____ HOW OFTEN HAVE THEY BEEN CLEANED_____

6. HAVE YOU HAD COMPLICATIONS WITH PRIOR DENTAL CARE ____ Y ____ N

   EXPLAIN _____

7. DO YOU CLENCH/GRIND YOUR TEETH ___Y___N 8. DOES YOUR JAW CLICK OR POP___ Y _____N

9. ARE YOUR TEETH SENSITIVE TO ___HEAT ___COLD_____SWEETS_____PRESSURE

10. DO YOUR GUMS HURT OR BLEED____Y____N WHEN _____

11. ARE YOU UNHAPPY WITH THE APPEARANCE OF YOUR TEETH_____ Y ____N

    EXPLAIN _____

12. DO YOU FEEL YOUR BREATH IS OFFENSIVE AT TIMES ___ Y_____N

13. HAVE YOU HAD GUM SURGERY____Y____N WHAT/WHEN_____

14. HAVE YOU HAD ORTHODONTICS (BRACES) _____Y ____N

15. HOW DO YOU FEEL ABOUT YOUR TEETH IN GENERAL _____

16. HAVE YOU HAD ANY UNPLEASANT DENTAL EXPERIENCE OR ANYTHING ABOUT DENTISTRY YOU

    DISLIKE _____

17. OTHER QUESTIONS/CONCERNS_____

18. WHOM MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE? PLEASE CIRCLE:

    ANOTHER PATIENT DAILY REGISTER ONLINE AD CHAMBER of COMMERCE NEWSPAPER

    ONLINE SEARCH VERIZON PHONE BOOK YELLOW BOOK COLUMBIA CTY PHONEBOOK

    NAME OF PERSON REFERRING YOU _____

Patient Signature: _____

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