DENTAL HISTORY (For New Patients)

Reason for visit ____

Name of previous dentist ______________________ Phone # ______________

Date of last dental visit ____________________ Last dental x-rays ____________________

Are you satisfied with the appearance of your teeth? Yes No

Please explain: ____

Would you like to change the appearance of your teeth? Yes No

Please explain: ____

Have you ever been advised that any dental treatment is necessary that has not yet been accomplished?

Yes No

Check if you have any of the following:

____Do your gums bleed while brushing or flossing?

____Are your teeth sensitive to hot, cold, sweet or sour foods/liquids?

____Do you feel pain in any of your teeth?

____Have you noticed any loosening of your teeth?

____Does food tend to become caught between your teeth?

____Do you have any sores or lumps in or near your mouth?

____Do you clinch or grind your teeth while awake or asleep?

____Have you had any head, neck or jaw injuries?

____Have you ever had any difficult extractions or prolonged bleeding?

____Have you ever had an upsetting dental experience?

____Is there anything about having dental treatments that bothers you?

If so, please explain ______________________________

____Do you bite your lips or cheeks frequently?

____Do you wear dentures or partials?

Have you ever experienced any of these jaw problems?

____Clicking

____Pain (joint, ear, side of face)

____Difficulty in chewing

____Difficulty opening or closing

Have you ever had?

____Orthodontics (braces)

____Oral Surgery

____Periodontal or Gum Treatment

____Teeth ground or bite adjusted

MEDICATIONS

Patient Name____ Date_____________________

Please list any ***PRESCRIPTION*** or ***OVER THE COUNTER*** medications you are currently taking. This includes vitamins, herbal, dietary and sexual enhancement drugs. Include the dosage, frequency taken and reason for taking medication.

DRUG	DOSAGE	FREQUENCY	REASON TAKING