DENTAL HISTORY

Today's Date: _____/_____/_____

Patient's Name: _____ Date of Birth: _____/_____/_____
Last First Middle Initial

1 Purpose of initial visit _____
2 Are you aware of a problem? _____
3 How long since your last dental visit? _____
4 What was done at that time? _____
5 Previous dentist _____ City _____ State _____ Phone _____-_____-_____
6 When were your teeth last cleaned? _____
7 Have you made regular visits? ..... *YES NO* How often: _____
8 Were dental x-rays taken? ..... *YES NO* Date of most recent x-rays: _____
9 Have you lost any teeth or had any teeth removed? ..... *YES NO*
When? _____ Why? _____
10 Have they been replaced? ..... *YES NO*
11 If yes, how have they been replaced?
Fixed bridge - year: _____ Removable bridge - year: _____ Denture - year: _____
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 had any complications with previous 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 your 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*
If yes, when? _____
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 Would you like whiter teeth? ..... *YES NO*
28 Do you feel your breath is offensive at times? ..... *YES NO*
29 Have you ever had gum treatment or surgery? ..... *YES NO*
If yes, describe: _____
Where? _____ When? _____
30 Have you had any orthodontic treatment? ..... *YES NO*
31 Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike? _____

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE:

PATIENT'S / GUARDIAN'S SIGNATURE _____ Date: _____/_____/_____

DENTIST'S SIGNATURE _____ Date: _____/_____/_____

-22/16