

PATIENT'S NAME _____

1. Purpose of initial visit _____
Last _____ First _____

Initial _____

Date of Birth _____

COMMENTS

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's name _____

Address: _____ Tel. () _____

6. When was the last time your teeth were cleaned? _____

CIRCLE THE APPROPRIATE ANSWER

7. Have you made regular visits? YES NO
How often? _____

8. Were dental x-rays taken? YES NO

9. Have any teeth been removed? YES NO
Why? _____

10. Have they been replaced? YES NO

11. How have they been replaced?

a. Fixed bridge _____ Age _____

b. Removable bridge _____ Age _____

c. Denture _____ Age _____

12. Are you happy with the replacement? YES NO
If no, explain _____

13. Would you like to know about permanent replacements? YES NO

14. Have you ever had any problems or 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 or 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 between 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
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 or shifted? YES NO

25. Are you happy with the appearance of your teeth? YES NO

26. How do you feel about your teeth in general? _____

27. Do you feel your breath is offensive at times? YES NO

28. Have you ever had gum treatment or surgery? YES NO

What _____

Where _____

When _____

29. Have you had any orthodontic work? YES NO

30. Have you had any unpleasant dental experiences or is there anything about
dentistry that you strongly dislike? _____

31. Do you have any questions or concerns? YES NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

ANEST.

MED. ALERT

DENTAL HISTORY