



DENTAL HISTORY

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

COMMENTS

- Purpose of your initial visit? _____

- Are you aware of any problems? _____

- How long since your last dental visit? _____
- Previous dentist's name _____ City _____
- When was the last time your teeth were professionally cleaned? _____

CIRCLE THE APPROPRIATE ANSWER, IF YOU DO NOT KNOW THE CORRECT ANSWER, PLEASE WRITE "DO NOT KNOW" ON THE LINE AFTER THE QUESTION.

- Did you make regular visits to the dentist? YES NO
How often? _____
- Have you ever had any of the following procedures?
a. Fixed bridge _____
b. Removable partial denture _____
c. Denture _____
d. Implant _____
- Are you unhappy with any of the above treatments? YES NO
If yes, explain _____
- Would you like to know about other options in treatment? YES NO
- Have you ever had any problems or complications with previous dental treatment? YES NO
If yes, explain _____
- Do you clench or grind your teeth? YES NO
- Does your jaw click or pop? YES NO
- Have you ever experienced any pain or soreness in the muscles of your face or around your ear? YES NO
- Do you have frequent headaches or neck and shoulder aches? YES NO
- Are any of your teeth sensitive to: Hot? Cold? Pressure? Sweets?
- Do your gums bleed or hurt? YES NO
- How often do you brush your teeth? _____
- How often do you use dental floss? _____
- Are any of your teeth loose, tipped, shifted or chipped? YES NO
- Are you unhappy with the appearance of your teeth? YES NO
- How do you feel about your teeth in general? _____

- Do you feel your breathe is offensive at times? YES NO
- Have you ever had gum treatment or surgery? YES NO
- Have you had any orthodontic work? _____
- Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike? _____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____