PATIENT NUMBER

PATIENT'S NAME _____ (Last) _____ (First) _____ (Initial) _____ (Date of Birth)

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's name _____
   Address: _____ Tel. ( ) _____
6. When was the last time your teeth were cleaned? _____

CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER, PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

7. Have you made regular visits? ..... YES NO
   How often: _____
8. Were dental x-rays taken? ..... YES NO
9. Have you lost any teeth or 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 unhappy with the replacement? YES NO
    If yes, 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 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
    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. 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

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

ANEST.

MED. ALERT

Form No. 150DH (Over)

DENTAL HISTORY