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PATIENT NUMBER

Patient's Name

Last

First

Initial

Date of Birth

COMMENTS

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

Phone

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

Check the appropriate response. If it is unknown, write "Don't Know" in the appropriate space.

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 so, why?

13. Would you like to know more about permanent replacements?..... Yes No

14. Have you ever had any problems or complications with dental treatment?..... Yes No

If so, explain?

15. Do you clench or grind your teeth?..... Yes No

16. Does your jaw click or pop?..... Yes No

17. Do you experience any pain/soreness in the muscles of your face/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 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 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 ever had 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

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S/ GUARDIAN'S SIGNATURE

DENTIST'S SIGNATURE

DATE

DATE

ANEST.

MED.ALERT

DENTAL HISTORY