
PATIENT NUMBER

welcome

Patient's Name _____
Last First Initial Date of Birth

- Purpose of initial visit _____
- Are you aware of a problem? _____
- How long since your last dental visit? _____
- What was done at that time? _____
- Previous dentist's name _____
Address: _____ Tel. _____
- When was the last time your teeth were cleaned? _____

COMMENTS

[Large empty box for patient or dentist comments]

- CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER, PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.
- Have you made regular visits? YES NO
How often: _____
 - Were dental x-rays taken? YES NO
 - Have you lost any teeth or have any teeth been removed? YES NO
Why? _____
 - Have they been replaced? YES NO
 - How have they been replaced?
a. Fixed bridge _____ Age _____
b. Removable bridge _____ Age _____
c. Denture _____ Age _____
d. Implant _____ Age _____
 - Are you unhappy with the replacement? YES NO
If yes, explain _____
 - Would you like to know about permanent replacements? 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 experienced any pain or soreness in the muscles or your face or around your ear? YES NO
 - Do you have frequent headaches, neckaches or shoulder aches? YES NO
 - Does food get caught in your teeth? YES NO
 - Are any of your teeth sensitive to: Hot? Cold? Sweets? Pressure?
 - Do your gums bleed or hurt? YES NO
When? _____
 - Do you experience dry mouth? YES NO
 - How often do you brush your teeth? _____ When? _____
 - Do you use dental floss? YES NO
How often? _____
 - 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 breath is offensive at times? YES NO
 - Have you ever had gum treatment or surgery? YES NO
What? _____
Where? _____
When? _____
 - Have you had any orthodontic work? _____
 - Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike? _____
 - Do you have any questions or concerns? YES NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

ANEST.

MED. ALERT

DENTAL HISTORY