Dental History

First Name: Middle Initial: Last Name: Birthdate: 01/01/1999

Purpose of initial visit:

Are you aware of a problem?

How long since you last dental visit?

What was done at that time?

Previous dentist's name:

Address and phone number:

When was the last time your teeth were cleaned?

Why did you leave your last dental office?

	Y	N
Have you made regular visits? How often?	☐	☐
Were dental x-rays taken?	☐	☐
Have you lost any teeth or have any teeth been removed? Why?	☐	☐
Have they been replaced?	☐	☐

How have they been replaced?

Fixed bridge	Age
Removable bridge	Age
Denture	Age
Implant	Age

	Y	N
Are you unhappy with the replacement? If yes, explain:	☐	☐
Would you like to know about permanent replacements?	☐	☐
Have you ever had any problems or complications with previous dental treatment? If yes, explain:	☐	☐
Do you clench or grind your teeth?	☐	☐
Does your jaw click or pop?	☐	☐
Have you experienced any pain or soreness in the muscles of your face or around your ear?	☐	☐
Do you have frequent headaches, neckaches, or shoulder aches?	☐	☐
Does food get caught in your teeth?	☐	☐

Are any of your teeth sensitive to:

☐ Hot? ☐ Cold? ☐ Sweets? ☐ Pressure?

	Y	N
Do your gums bleed or hurt? When?	☐	☐

Do you experience dry mouth? ☐ ☐

How often do you brush your teeth, and when?

Do you use dental floss? ☐ ☐
How often

Are any of your teeth loose, tipped, shifted, or chipped? ☐ ☐

Are you unhappy with the appearance of your teeth? ☐ ☐

How do you feel about your teeth in general?

	Y	N
Do your feel your breath is offensive at times?	☐	☐
Have you ever had gum treatment or surgery?	☐	☐

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?

What have you experienced before that you would hope to find in our office?

What have you experienced before that you would hope to find in our office?

What are the time, money, or other considerations you will want us to understand?

Is there anything else we should know in order to work most effectively with you?

I certify that the above information is complete and accurate.
Patient Signature (Name):
Date: