

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

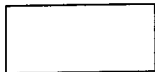
CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

- 7. Have you had regular dental visits? YES NO
How often? _____
- 8. Does food get caught in your teeth? YES NO
- 9. Are any of your teeth sensitive to: Hot? Cold? Sweets? Pressure?
- 10. Do your gums bleed or hurt? YES NO
When? _____
- 11. How often do you brush your teeth? _____ When? _____
- 12. Do you use dental floss? YES NO
How often? _____
- 13. Are any of your teeth loose, tipped, shifted or chipped? YES NO
- 14. Do you feel your breath is offensive at times? YES NO
- 15. Have you ever had gum treatment or surgery? YES NO
What _____
Where _____
When _____
- 16. Have you had any orthodontic work? YES NO
- 17. Have you lost any teeth or have any teeth been removed? YES NO
Why? _____
- 18. Have your lost or missing teeth been replaced? YES NO
- 19. How have they been replace?
a). Fixed Bridge _____ Age _____
b). Partial Denture _____ Age _____
c). Full Denture _____ Age _____
- 20. Are you happy with the replacement? YES NO
If NO, explain: _____
- 21. Would you like to know about permanent replacements? YES NO
- 22. Do you clench or grind your teeth? YES NO
- 23. Does your jaw click or pop? YES NO
- 24. Have you experienced any pain or soreness in the muscles or your face or around your ears? YES NO
- 25. Do you have frequent headaches, neckaches or shoulder aches? YES NO
- 26. Are you unhappy with the appearance of your teeth? YES NO
- 27. How do you feel about your teeth in general? _____
- 28. Have you had problems or complications with previous dental treatment? YES NO
If yes, explain: _____
- 29. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike? _____
- 30. 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 _____



DENTAL HISTORY

