Patient's Name _____ ___/___/_____
Last First MI Date of Birth

**COMMENTS: OFFICE USE**

1. Reason for todays visit _____
2. Are you aware of any problem? _____
3. How long since your last dental visit? _____
4. What was done at that time? _____
5. Previous Dentist's Name: _____
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 dental visits?.....YES / NO
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 _____ When? _____
    b. Removable Bridge _____ When? _____
    c. Denture _____ When? _____
    d. Implant _____ When? _____
12. Are you happy with the replacement? .....YES / NO
    If not, 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? _____
15. Do you clench or grind your teeth?.....YES / NO
16. Does your jaw pop or click? .....YES / NO
17. Have you experienced any pain or soreness in the muscles in 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? When? _____ YES / NO
22. Have you ever had gum treatment or surgery?.....YES / NO
    What? _____
    Where? _____
    When? _____
23. Do you feel your breath is offensive at times?.....YES / NO
24. How often do you brush your teeth daily? 1X 2X 3X More When? _____
25. Do you use dental floss?.....YES / NO
    How often? _____
26. Are any of your teeth: Loose? Tipped? Shifted? Chipped?
27. Are you happy with the appearance of your teeth?.....YES / NO
28. How do you feel about your teeth in general? _____
29. Have you 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 / NO

**I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.**

**PATIENT'S / GUARDIAN'S SIGNATURE** _____ **DATE** _____

**DENTIST'S SIGNATURE** _____ **DATE** _____

# Dental History