DENTAL HISTORY

Dentist's comments:

Your Name: Date of Birth:	
What is the purpose of your visit?	
Are you aware of any specific problem?	
How long has it been since your last dental visit?	
What was done at that time?	
How long has it been since your teeth were cleaned?	
Have you made regular dental visits?	☐ Yes ☐ No
If yes, how often?	
Name of Previous Dentist:	
Have you lost any teeth or had any removed?	☐ Yes ☐ No
Have you had any teeth replaced?	☐ Yes ☐ No
If yes, how have they been replaced? *(circle all that apply)* Fixed bridge ☐ Removable bridge ☐ Denture ☐	
Are you happy with the replacement?	☐ Yes ☐ No
Would you like to know about permanent replacements?	☐ Yes ☐ No
Have you ever had complications with previous dental treatment?	☐ Yes ☐ No
If yes, please comment:	
Do you clench or grind your teeth?	☐ Yes ☐ No
Does your jaw click or pop?	☐ Yes ☐ No
Do you frequently experience pain or soreness in the muscles of your face or around your ear?	☐ Yes ☑ No
Do you have frequent headaches, neck aches or shoulder aches?	☐ Yes ☐ No
Does food get caught between your teeth?	☐ Yes ☐ No
Are any of your teeth sensitive to *(circle all that apply):* Hot ☐ cold ☐ sweets ☐ pressure ☐	
How often do you brush your teeth?	
Do you use dental floss or toothpicks?	☐ Yes ☐ No
Are you happy with the appearance of your teeth?	☐ Yes ☐ No
Do you have any discolored teeth that bother you?	☐ Yes ☐ No
How do you feel about your teeth in general?	
Have you ever had gum treatment or surgery?	☐ Yes ☐ No
Have you had any orthodontic care (braces)?	☐ Yes ☐ No
Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike?	☐ Yes ☐ No
Do you have any other questions or concerns	☐ Yes ☐ No

I certify that the above information is complete and accurate:

_____ _____

Date Signature of patient, parent, or guardian

_____ _____

Date Signature of dentist