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? ______________________________

**COMMENTS**

**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

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

*PATIENT'S / GUARDIAN'S SIGNATURE* ______________________________ *DATE* ________

*DENTIST'S SIGNATURE* ______________________________ *DATE* ________

# DENTAL HISTORY