PATIENTS NAME: _____

Last First Initial Date of Birth

1. Purpose of initial visit _____
2. How long since your last dental visit? _____
3. What was done at that time? _____
4. Previous Dentist name_____
5. Address: _____ Tel. ( ) _____

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

6. Have you made regular visits? …….. YES NO
   How often: _____
7. Were dental x-rays taken? ……. YES NO
8. Have you lost any teeth or have any teeth been removed? …… YES NO
   Why? _____
9. Have they been replaced? ……. YES NO
10. How have they been replaced?
    a. Fixed Bridge _____ Age _____
    b. Removable bridge _____ Age _____
    c. Implant _____ Age _____
11. Are you unhappy with the replacement? …….. YES NO
    If yes, explain: _____
12 Have you had any complications with dental treatment? ……. YES NO
    If yes, explain: _____
13. Do you clench or grind your teeth? …….. YES NO
14. Does your jaw click or pop? …… YES NO
15. Have you experienced any pain or soreness in the muscles of your face or around your ear? ……. YES NO
16. Do you have frequent headaches, neck or shoulder aches? …. YES NO
17. Does food get caught in your teeth? …….. YES NO
18. Are any of your teeth sensitive to: ☐Hot? ☐Cold? ☐Sweets? ☐Pressure?
19. Do your gums bleed or hurt? …….. YES NO
    When? _____
20. How often do you brush your teeth? _____ When? _____
21. Do you use dental floss? ……. YES NO
    How often? _____
22. Are any of your teeth loose, tipped, shifted or chipped? ….. YES NO
23. Are you unhappy with the appearance of your teeth? ……... YES NO
24. How do you feel about your teeth in general? _____
    _____
25. Do you feel your breath is offensive at times? …… YES NO
26. Have you ever had gum treatment for surgery? …….. YES NO
    What? _____
    Where? _____ When? _____
27. Have you had any orthodontic work? ……. YES NO
28. Have you had any unpleasant dental experiences or is there anything about the dentist you strongly dislike?
    _____

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

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

DENTIST'S SIGNATURE _____ DATE: _____

ANEST.

DENTAL HISTORY

MED. ALERT