Dental History

Today's Date: _____

Patient Name (Last, First, Initial): _____DOB:_____

Purpose of initial visit: _____

Are you aware of a problem?_____

How long since your last dental visit?_____ What was done at that time?_____

Previous dentist's name & phone number:_____

When was your last dental cleaning?_____

Please circle **YES** or **NO** for the following questions:

Have you visited the dentist regularly?.....Yes No

How often?_____ Were dental x-rays taken at your last visit?.....Yes No

Have you ever had any problems or complications with previous dental treatment?.....Yes No

If yes, please explain:_____

_____

Do you clench or grind your teeth?.....Yes No

Does your jaw click or pop?.....Yes No

Have you experienced any pain or soreness of the muscles in your face or around your ear?.....Yes No

Do you have frequent headaches, neck aches or shoulder aches?.....Yes No

Does food get caught in your teeth?.....Yes No

Are your teeth sensitive to: (please circle all that apply) Hot? Cold? Sweets? Pressure?

Do your gums bleed or hurt?.....Yes No

When?_____

Do you experience dry mouth?.....Yes No

How often do you brush?_____When?_____

Do you use dental floss? Yes No How often?_____

Are any of your teeth chipped, loose or shifted that are of concern to you?.....Yes No

Are you unhappy with the appearance of your teeth?.....Yes No

Have you ever had gum treatment, surgery or specialized cleaning?.....Yes No

If yes, what kind, when and where did you have this done?_____

Have you ever had orthodontic work or braces?.....Yes No

Are there any other concerns or questions you have? If so, please list?_____

_____

_____

Additional Information

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

Patient's / Guardian's Signature_____ Date_____

ANEST.

MED. ALERT

Dental History