

Patient's Name _____

Date of Birth _____

Reason for today's visit: _____

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

Name of Previous Dentist: _____

Location of Office: _____ Phone: _____

Circle One:

DENTIST'S USE

1. Have you made regular visits to the dentist? YES NO
2. Have you lost any teeth or have any been removed? YES NO
If "Yes," why? _____
3. Have any lost/removed teeth been replaced? YES NO
If "Yes," how have they been replaced? (please circle)
Fixed Bridge Removable Bridge Denture Implant(s)
4. Have you ever had problems or complications with previous dental treatment? If "Yes," explain: YES NO

5. Do you clench or grind your teeth? YES NO
6. Does your jaw click or pop? YES NO
7. Have you experienced pain/soreness in the muscles of your face or around the ear? YES NO
8. Do you have frequent headaches, neckaches or shoulder aches? YES NO
9. Are any of your teeth sensitive? YES NO
If "Yes," to which of these? **Hot Cold Sweets Pressure**
10. Do your gums bleed or hurt? YES NO
If "Yes," when? _____
11. How often do you brush your teeth? _____
When do you brush? _____
12. Do you use dental floss? YES NO
If "Yes," how often? _____
13. Do you feel your breath is offensive sometimes? YES NO
14. Have you ever had gum treatment or surgery? YES NO
If "Yes," what, when and where? _____

15. Have you had any orthodontic work? YES NO
16. Have you had any unpleasant dental experiences? YES NO

I certify that the above information is complete and accurate.

Patient/Guardian's Signature _____

Date _____

Dentist's Signature _____

Date _____

DENTAL HISTORY