
PATIENT NUMBER

welcome

Patient's Name _____
Last First Initial Date of Birth

- 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 _____
Address: _____ Tel. _____
- 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.

- Have you made regular visits?YES NO
How often: _____
- Were dental x-rays taken?YES NO
- Have you lost any teeth or have any teeth been removed?YES NO
Why? _____
- Have they been replaced?YES NO
- How have they been replaced?
a. Fixed bridge _____ Age _____
b. Removable bridge _____ Age _____
c. Denture _____ Age _____
- Are you unhappy with the replacement?YES NO
If yes, explain _____
- Would you like to know about permanent replacements?YES NO
- Have you ever had any problems or complications with previous dental treatment? ...YES NO
If yes, 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 in the muscles or your face or around your ear?YES NO
- Do you have frequent headaches, neckaches or shoulder aches?YES NO
- Does food get caught in your teeth?YES NO
- Are any of your teeth sensitive to: Hot? Cold? Sweets? Pressure?
- Do your gums bleed or hurt?YES NO
When? _____
- How often do you brush your teeth? _____ When? _____
- Do you use dental floss?YES NO
How often? _____
- Are any of your teeth loose, tipped, shifted or chipped?YES NO
- Are you unhappy with the appearance of your teeth?YES NO
- How do you feel about your teeth in general? _____
- Do you feel your breath is offensive at times?YES NO
- Have you ever had gum treatment or surgery?YES NO
What? _____
Where? _____
When? _____
- Have you had any orthodontic work? _____
- Have you had any unpleasant dental experiences or is there anything about dentistry that you .. strongly dislike? _____
- Do you have any questions or concerns?YES NO

Large empty box for patient comments.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

ANEST. _____

MED. ALERT _____

DENTAL HISTORY