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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 _____
 d. Implant _____ 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? _____
- Do you experience dry mouth? YES NO
- 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

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