Dental History

What is the purpose of today's visit? ____________________

How long since your last visit? ____________________
What treatment did you receive? ____________________
Previous Dentist's Name: ____________________
Address: ____________________ Phone: ____________________
How long since you have had your teeth cleaned? ____________________

Please circle Yes or No for the following questions:

Have you made regular visits? .... Yes No
How often? ____________________
Were dental radiographs taken? .... Yes No
Have you ever lost teeth or had them removed? .... Yes No
Why? ____________________
Have they been replaced? .... Yes No
If so, how were they replaced?
Fixed Bridge ____________________ Age ____________
Removable Partial ____________________ Age ____________
Full Denture ____________________ Age ____________
Implant Therapy ____________________ Age ____________
Are you unhappy with the replacement? .... Yes No
If yes, please explain: ____________________
Would you like to discuss replacement options? .... Yes No
Do you clench or grind your teeth? .... Yes No
Doesyourjawclickorpop? .... Yes No
Have you experienced pain or soreness in the muscles of your face or around your ear? .... Yes No
Do you have frequent headaches, neck pain or shoulder aches? .... Yes No
Does food ever get caught between your teeth? .... Yes No
Are any of your teeth sensitive to: ___Hot? ___Cold? ___Sweets? ___Pressure? ___Biting?
Do your gums bleed or hurt? .... Yes No
If yes, when? ____________________
How often do you brush? ____________________ Floss? ____________________
Do you have any loose, broken, or shifted teeth? .... Yes No
Are you unhappy with the appearance of your teeth? .... Yes No
Is there anything you would like to change about your teeth? .... Yes No
Have you ever had gum treatment or surgery? .... Yes No
If yes, when? ____________ what was done? ____________________
Have you ever had orthodontics (braces)? .... Yes No
Have you ever had any complications following dental treatment? .... Yes No
If so, explain: ____________________
Do you have anything about dentistry that you strongly dislike or have any unpleasant experiences or concerns?

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Patient/Guardian Signature: ____________________