

PATIENT'S NAME \_\_\_\_\_  
Last First Initial Date of Birth

1. Purpose of initial visit \_\_\_\_\_
2. Are you aware of a problem? \_\_\_\_\_
3. How long since your last dental visit? \_\_\_\_\_
4. What was done at that time? \_\_\_\_\_
5. Previous dentist's name \_\_\_\_\_  
Address: \_\_\_\_\_ Tel. ( ) \_\_\_\_\_
6. 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.*

7. Have you made regular visits? YES NO  
How often? \_\_\_\_\_
8. Were dental x-rays taken? YES NO
9. Have you lost any teeth or have any teeth been removed?  
YES NO  
Why? \_\_\_\_\_
10. Have they been replaced? YES NO
11. How have they been replaced?  
a. Fixed bridge Age \_\_\_\_\_  
b. Removable bridge Age \_\_\_\_\_  
c. Denture Age \_\_\_\_\_
12. Are you unhappy with the replacement? YES NO  
If yes, explain: \_\_\_\_\_
13. Would you like to know about permanent replacements?  
YES NO
14. Have you ever had any problems or complications with previous dental treatment? YES NO  
If yes, explain: \_\_\_\_\_
15. Do you clench or grind your teeth? YES NO
16. Does your Jaw click or pop? YES NO
17. Have you experienced any pain or soreness in the muscles or your face or around your ear? YES NO
18. Do you have frequent headaches, neck-aches or shoulder aches?  
YES NO
19. Does food get caught in your teeth? YES NO
20. Are any of your teeth sensitive to:  
Hot? Cold? Sweets? Pressure?
21. Do your gums bleed or hurt? YES NO  
When? \_\_\_\_\_
22. How often do you brush your teeth? \_\_\_\_\_ When? \_\_\_\_\_
23. Do you use dental floss? YES NO  
How often? \_\_\_\_\_
24. Are any of your teeth loose, tipped, shifted or chipped?  
YES NO
25. Are you unhappy with the appearance of your teeth?  
YES NO
26. How do you feel about your teeth in general? \_\_\_\_\_
27. Do you feel your breath is offensive at times? YES NO
28. Have you ever had gum treatment or surgery? YES NO  
What? \_\_\_\_\_  
Where? \_\_\_\_\_  
When? \_\_\_\_\_
29. Have you had any orthodontic work? YES NO
30. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike?  
\_\_\_\_\_

31. 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 \_\_\_\_\_

**DENTAL HISTORY**