DENTAL HISTORY

1. What is your major dental concern? _____

_____

2. Date of your last visit to a dentist? _____
3. Reason for your last visit or series of visits? _____
4. Date you last had dental x-rays taken? _____
5. Have you always had your teeth cleaned at least once a year? ..... Yes No Don't Know
6. Do you use dental floss once a day? ..... Yes No Don't Know
7. Is there fluoride in your drinking water? ..... Yes No Don't Know
8. Do you brush your teeth at least once a day? ..... Yes No Don't Know
9. Do you use toothpaste that contains fluoride? ..... Yes No Don't Know
10. Do you need to have antibiotic premedication before dental treatment? ..... Yes No Don't Know
11. Have you ever fainted during a dental visit? ..... Yes No Don't Know

    If yes, explain: _____
12. Have you experienced an unusual reaction to dental medication or anesthetic? ..... Yes No Don't Know
13 Have you experienced prolonged bleeding following dental treatment? ..... Yes No Don't Know

    If yes, explain: _____
14. Have you had any other complications following dental treatment? ..... Yes No Don't Know

    If yes, explain: _____
15. Have you had any injury to teeth, jaws or face? ..... Yes No Don't Know

    If yes, explain: _____
16. Are you happy with the appearance of your teeth? ..... Yes No Don't Know
17. Do your gums bleed when you brush your teeth or when you eat? ..... Yes No Don't Know
18. Does food or dental floss catch between your teeth? ..... Yes No Don't Know
19. Are some of your teeth becoming loose? ..... Yes No Don't Know
20. Are there spaces between your teeth now where there were none before? ..... Yes No Don't Know
21. Are any of your teeth sensitive to hot, cold or pressure? ..... Yes No Don't Know
22. Do any of your teeth ache? ..... Yes No Don't Know
23. Do you experience pain or clicking in your jaw joints? ..... Yes No Don't Know
24. Are there any sores or growths in your mouth? ..... Yes No Don't Know
25. Are you worried about receiving dental treatment? ..... Yes No Don't Know
26. Do you have any other dental concerns or complaints? ..... Yes No Don't Know

    If yes, explain: _____

_____

SIGNATURE OF PATIENT: *I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand it is very important to report any changes in my medical or dental status to the dentist at the earliest possible time, and I agree to do so. I give permission to the dentist to obtain from my physician any additional information regarding my medical history needed to provide me the best dental treatment possible.*

PERSON COMPLETING THIS FORM: Signature _____ Date _____

If other than patient, indicate relationship: _____