Welcome _____ Age _____ Date _____

Med Alert

Patient's Name Date of Birth / / **q** Female **q** Male

Last First M. Initial

1. Purpose of 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: _____
6. When was the last time your teeth were cleaned: _____

CIRCLE THE APPROPRIATE ANSWER. IF YOU DO NOT KNOW THE CORRECT ANSWER, PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

7. Have you made regular visits: _____ YES NO
8. Were dental x-rays taken: _____ YES NO
9. Have you lost any teeth or have any teeth been removed _____ YES NO
10. Have they been replaced _____ YES NO
11. How have they been replaced?
    - g. Fixed Bridge _____ Age _____
    - h. Removable bridge _____ Age _____
    - i. Denture _____ Age _____
    - j. Implant _____ Age _____
12. Are you unhappy with the replacement? _____ YES NO
13. Would you like to know about permanent placement _____ YES NO
14. Have you ever had any problems or complications with previous dental treatment?
    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 ears? _____ 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: **r** Hot? **r** Cold? **r** Sweets? **r** Pressure?
21. Do your gums bleed or hurt? _____ YES NO
22. Do you experience Dry Mouth _____ YES NO
23. How often do you brush your teeth? _____ When? _____
24. Do you use dental floss? _____ YES NO
25. Are any of your teeth loose, shifted or chipped? _____ YES NO
26. Are you unhappy with the appearance of your teeth? _____ YES NO
27. How do you feel about your teeth in general? _____ YES NO
28. Do you feel your breath is offensive at times? _____ YES NO
29. Have you ever had gum treatment or surgery? _____ YES NO
    - What? _____
    - Where? _____
    - When? _____
30. Have you had any orthodontic work? _____
31. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike? _____

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S GUARDIAN'S SIGNATURE: _____ DATE _____

DENTIST SIGNATURE: _____ DATE _____

DENTAL HISTORY

Advanced Dental Care