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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? _____
- 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

COMMENTS

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