

_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

PATIENT NUMBER

welcome

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

[Large empty box for patient or dentist 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 _____
d. Implant _____ 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, neckaches 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. Do you experience dry mouth?YES NO
- 23. How often do you brush your teeth? _____ When? _____
- 24. Do you use dental floss?YES NO
How often? _____
- 25. Are any of your teeth loose, tipped, 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? _____
- 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? _____
- 32. 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 _____

ANEST. _____

MED. ALERT _____

DENTAL HISTORY