DENTAL HISTORY

What is the purpose of today's visit? ______________________

How long since your last visit? ______________________

What treatment did you receive? ______________________

Previous dentist's name: ______________________

Address: ______________________ Phone: ______________________

How long since you have had your teeth cleaned? ______________________

Please circle Yes or No for the following questions:

Have you made regular visits? ______________________ Yes No

How often? ______________________

Were dental radiographs taken? ______________________ Yes No

Have you ever lost teeth or had them removed? ______________________ Yes No

Why? ______________________

Have they been replaced? ______________________ Yes No

If so, how were they replaced?

___ Fixed Bridge ___ Removable Partial ___ Full Denture ___ Implant Therapy Age _______

Are you unhappy with the replacement? ______________________ Yes No

If yes, please explain: ______________________

Would you like to discuss replacement options? ______________________ Yes No

Do you clench or grind your teeth? ______________________ Yes No

Does your jaw click or pop? ______________________ Yes No

Have you experienced pain or soreness in the muscles of your face or around your ear? ______________________ Yes No

Do you have frequent headaches, neck pain or shoulder aches? ______________________ Yes No

Does food ever get caught between your teeth? ______________________ Yes No

Are any of your teeth sensitive to: ___ Hot? ___ Cold? ___ Sweets? ___ Pressure? ___ Biting?

Do your gums bleed or hurt? ______________________ Yes No

If yes, when? ______________________

How often do you brush? ______________________ Floss? ______________________

Do you have any loose, broken or shifted teeth? ______________________ Yes No

Are you unhappy with the appearance of your teeth? ______________________ Yes No

Is there anything you would like to change about your teeth? ______________________ Yes No

Have you ever had gum treatment or surgery? ______________________ Yes No

If yes, when? ______________________ What was done? ______________________

Have you ever had orthodontics (braces)? ______________________ Yes No

Have you ever had any complications following dental treatment? ______________________ Yes No

If so, explain: ______________________

Do you have anything about dentistry that you strongly dislike or have any unpleasant experiences or concerns?

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Patient/Guardian Signature: ______________________