Dental History

1. Purpose of initial visit____

2. How long since your last dental visit? ________________________________

3. What was done at that time? ________________________________

4. Previous dentist name ________________________ Telephone #________________

5. 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

6. Were Dental x-rays taken? .... YES.......... NO.......

7. Have you lost any teeth or have any teeth been removed..... YES.... NO.......... Why?________________________

8. Have they been replaced?.. YES.......... NO.......

9. Are you unhappy with the replacement? .... YES........ NO........ If yes, explain________________________

10. Have you ever had any problems or complications with previous dental treatment?.................. YES.......... NO........ If yes explain,

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11. Do you clench or grind your teeth?........ YES................ NO.................... Does your jaw click or pop?.................. YES.............. NO..........

12. Have you experienced any pain or soreness in the muscles or your face or around your ear? .... YES................ NO..........

13. Do you have frequent headaches, neck aches or shoulder aches? .... YES................ NO..........

14. Does food get caught in your teeth?.. YES................ NO..........

15. Do your gums bleed or hurt?....... YES...... NO........ WHEN?________________________

16. Do you experience dry mouth? .... YES................ NO..........

17. How often do you brush your teeth?________________________ When?________________

18. Do you use dental floss?.......... YES......... NO.......... How often? ________________________

19. Are you unhappy with the appearance of your teeth? .... YES................ NO..........

20. How do you feel about your teeth in general? ________________________

21. Have you ever had gum treatment?.. YES................ NO..........

22. Have you ever had braces?.. YES................ NO..........

23. Do you have any questions of concerns? ________________________

I certify that the above information is complete and accurate

Patients/Guardian's Signature____ Date________________