

# WELCOME

Patient's Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

1. Purpose of initial visit \_\_\_\_\_
2. Are you aware of any problems? \_\_\_\_\_
3. How long since your last dental visit? \_\_\_\_\_ What was done at that time? \_\_\_\_\_
4. Previous dentist's name \_\_\_\_\_ Telephone number \_\_\_\_\_  
Address: \_\_\_\_\_
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 AFTER THE QUESTION.

6. Have you made regular visits to the dentist?..... YES NO  
How often: \_\_\_\_\_
7. Were dental x-rays taken at your last appointment?..... YES NO
8. Have you lost any teeth or have any teeth been removed?..... YES NO  
Why? \_\_\_\_\_ Have they been replaced?..... YES NO
9. How have they been replaced?  
a. Fixed bridge \_\_\_\_\_ Age of bridge \_\_\_\_\_  
b. Removable bridge \_\_\_\_\_ Age of bridge \_\_\_\_\_  
c. Denture \_\_\_\_\_ Age of denture \_\_\_\_\_  
d. Implant \_\_\_\_\_ Age of Implant \_\_\_\_\_
10. Are you unhappy with the replacement?..... YES NO  
If yes, please explain: \_\_\_\_\_
11. Have you ever had any problems or complaints with previous dental treatment, or is there anything about dentistry that you strongly dislike? \_\_\_\_\_
12. Do you clench or grind your teeth?..... YES NO
13. Does your jaw click or pop?..... YES NO
14. Have you experienced any pain or soreness in the muscles of your face or around your ear?..... YES NO
15. Do you have frequent headaches, necklaces or shoulder aches?..... YES NO
16. Does food get caught in your teeth?..... YES NO
17. Are any of your teeth sensitive to  Hot?  Cold?  Sweets?  Pressure?
18. Do your gums bleed or hurt?..... YES NO  
When? \_\_\_\_\_
19. How often do you brush your teeth? \_\_\_\_\_ When? \_\_\_\_\_
20. Do you use dental floss?..... YES NO  
How often? \_\_\_\_\_
21. Are any of your teeth loose, tipping, shifted or chipped?..... YES NO
22. Are you unhappy with the appearance of your teeth?..... YES NO
23. How do you feel about your teeth in general? \_\_\_\_\_
24. Do you feel your breath is offensive at times?..... YES NO
25. Have you ever had gum treatment or surgery?..... YES NO  
What? \_\_\_\_\_ When? \_\_\_\_\_ Where? \_\_\_\_\_
26. Have you had any orthodontic work?..... YES NO
27. Do you have any questions or concerns? \_\_\_\_\_

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S / GUARDIAN'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

DENTIST'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

## DENTAL HISTORY