

**Patient Name**

\_\_\_\_\_

Last

First

Initial

**Soc. Sec. #**

\_\_\_\_-\_\_\_\_-\_\_\_\_

**Birthdate**

\_\_\_\_/\_\_\_\_/\_\_\_\_

Month

Day

Year

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: \_\_\_\_\_ Phone: \_\_\_\_\_
  6. 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.**
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 \_\_\_\_\_
  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 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 of 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  Pressures
  21. Do your gums BLEED OR HURT? ..... Yes No  
When? \_\_\_\_\_
  22. How often do you brush your teeth? \_\_\_\_\_
  23. Do you use DENTAL FLOSS? ..... Yes No
  24. Are any of your teeth LOOSE, TIPPED, SHIFTED or CHIPPED? \_\_\_\_\_
  25. Are you unhappy with the APPEARANCE of your teeth? \_\_\_\_\_
  26. HOW DO YOU FEEL about your teeth in general? \_\_\_\_\_
  27. Do you feel your BREATH IS OFFENSIVE at times? \_\_\_\_\_
  28. Have you ever had GUM TREATMENT or SURGERY? \_\_\_\_\_  
What? \_\_\_\_\_  
When? \_\_\_\_\_  
Where? \_\_\_\_\_
  29. Have you had any ORTHODONTIC work? \_\_\_\_\_
  30. Have you had any UNPLEASANT dental experiences or is there anything about  
dentistry that you STRONGLY DISLIKE? \_\_\_\_\_
  31. Do you have any questions or concerns? \_\_\_\_\_

**COMMENTS**

Large empty box for comments.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

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

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

**DENTAL HISTORY**

Cut immediately ABOVE this line