

PATIENT'S NAME _____
Last First Initial

_____ Date of Birth

COMMENTS

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? _____

CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

- | | | |
|---|-----|----|
| 7. Are you unhappy with the appearance of your teeth? _____ | YES | NO |
| 8. How do you feel about your teeth in general? _____ | | |
| 9. Have you made regular visits? _____
How often? _____ | YES | NO |
| 10. Were dental X-Rays taken? _____ | YES | NO |
| 11. Have you lost any teeth or any teeth been removed? _____
Why? _____ | YES | NO |
| 12. Have they been replaced? _____ | YES | NO |
| 13. How have they been replaced?
a. Fixed bridge _____ Age _____
b. Removable bridge _____ Age _____
c. Denture _____ Age _____ | | |
| 14. Are you unhappy with the replacement? _____
If yes, explain why _____ | YES | NO |
| 15. Would you like to know about the permanent replacements? _____ | YES | NO |
| 16. Have you had any complications with previous dental treatment?.....
If yes, explain _____ | YES | NO |
| 17. Do you clench or grind your teeth? _____ | YES | NO |
| 18. Does your jaw click or pop? _____ | YES | NO |
| 19. Have you experienced any pain or soreness in the muscles of your face
around the ear? _____ | YES | NO |
| 20. Do you have frequent headaches, neck aches or shoulder aches? _____ | YES | NO |
| 21. Does food get caught in your teeth? _____ | YES | NO |
| 22. Are your teeth sensitive to <input type="checkbox"/> Hot <input type="checkbox"/> Cold <input type="checkbox"/> Sweet <input type="checkbox"/> Pressure | | |
| 23. Do your gums bleed or hurt? _____
If yes, When? _____ | YES | NO |
| 24. How often do you brush your teeth? _____ When _____ | | |
| 25. Do you use dental floss? _____
How often? _____ | YES | NO |
| 26. Are any of your teeth loose, tipped, shifted or chipped? _____ | YES | NO |
| 27. Do you feel your breath is offensive at times? _____ | YES | NO |
| 28. Have you ever had gum treatment or surgery? _____
Which? _____
Where? _____
When? _____ | YES | NO |
| 29. Have you had any orthodontic work done? _____ | YES | NO |
| 30. Have you had any unpleasant dental experience or is there anything about
dentistry you strongly dislike? _____ | YES | NO |
| 31. Do you have any questions or concerns? _____ | YES | NO |

I certify that the above information is complete and accurate

PATIENT'S / GUARDIAN SIGNATURE _____ DATE _____
DENTIST'S SIGNATURE _____ DATE _____

ANEST

MED ALERT

DENTAL HISTORY