



PATIENT NUMBER

Patient's Name _____ Last _____ First _____ Initial _____ Date of Birth _____

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. 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 _____
d. Implant _____ 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 ever 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 or 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? Pressure?
 21. Do your gums bleed or hurt?YES NO
When? _____
 22. Do you experience dry mouth?YES NO
 23. How often do you brush your teeth? _____ When? _____
 24. Do you use dental floss?YES NO
How often? _____
 25. Are any of your teeth loose, tipped, shifted or chipped?YES NO
 26. Are you unhappy with the appearance of your teeth?YES NO
 27. How do you feel about your teeth in general? _____
 28. Do you feel your breath is offensive at times?YES NO
 29. Have you ever had gum treatment or surgery?YES NO
What? _____
Where? _____
When? _____
 30. Have you had any orthodontic work? _____
 31. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike? _____
 32. Do you have any questions or concerns?YES NO

COMMENTS

Large empty box for patient or dentist comments.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE
PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____
DENTIST'S SIGNATURE _____ DATE _____

ANEST.

MED. ALERT

DENTAL HISTORY