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(800) 243-4675

PATIENT NUMBER

welcome

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

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

Form No. T150DH