Patient Dental History

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

If Child: Parent's Name _____

Previous dentist's name, address, tel. _____
Date of last dental visit _____ Last dental cleaning _____ Last Full Mouth X-rays _____
How often do you brush you teeth? _____ How often do you floss? _____
Have you made regular visits to the dentist? ..... YES NO
How often: _____
Have you lost any teeth or have any teeth been removed? ..... YES NO
Why? _____
Have they been replaced? ..... YES NO
How have they been replaced?
Fixed bridge _____ Age _____
Removable bridge _____ Age _____
Denture _____ Age _____
Implant _____ Age _____
Are you unhappy with the replacement? ..... YES NO
If yes, explain _____
Would you like to know about permanent replacements? ..... YES NO
Have you ever had any problems or complications with previous dental treatment? YES NO
If yes, explain _____
Do you clench or grind your teeth? ..... YES NO
Does your jaw click or pop? ..... YES NO
Do you have frequent headaches, neck aches or shoulder aches? ..... YES NO
Does food get caught in our teeth? ..... YES NO
Are your teeth sensitive to: □ Hot? □ Cold? □ Sweets? □ Pressure?
Do your gums bleed or hurt? ..... YES NO
When? _____
Are any of your teeth loose, tipped, shifted of chipped? ..... YES NO
Do you feel your breath is offensive at times? ..... YES NO
Have you ever had gum treatment or surgery? ..... YES NO
When? _____ Where? _____
Have you had any orthodontic work? _____
Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike? _____

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S OR GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____