



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
6. When was the last time your teeth were cleaned?
7. Have you made regular visits?
8. Were dental x-rays taken?
9. Have you lost any teeth or have any teeth been removed?
10. Have they been replaced?
11. How have they been replaced?
12. Are you unhappy with the replacement?
13. Would you like to know about permanent replacements?
14. Have you ever had any problems or complications with previous dental treatment?
15. Do you clench or grind your teeth?
16. Does your jaw click or pop?
17. Have you experienced any pain or soreness in the muscles or your face or around your ear?
18. Do you have frequent headaches, neckaches or shoulder aches?
19. Does food get caught in your teeth?
20. Are any of your teeth sensitive to:
21. Do your gums bleed or hurt?
22. How often do you brush your teeth?
23. Do you use dental floss?
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?
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 patient comments.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE DATE

DENTIST'S SIGNATURE DATE

ANEST. box

MED. ALERT box

DENTAL HISTORY