



## DENTAL HISTORY

### Comments

1. Purpose of initial visit  
\_\_\_\_\_
2. How long since your last dental visit?  
\_\_\_\_\_
3. What was done at that time?  
\_\_\_\_\_
4. Previous Dentist's name  
\_\_\_\_\_
5. 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" IN THE COMMENTS SECTION.**

- |  |     |    |
|--|-----|----|
| 6. Are you aware of a problem?   | YES | NO |
| 7. Have you made regular visits to a dental office?  | YES | NO |
| 8. Were dental x-rays taken?   | YES | NO |
| 9. Are you missing any teeth?  | YES | NO |
| 10. Would you like to know about permanent replacements?   | YES | NO |
| 11. Have you ever had any problems or complications with previous dental treatment? If yes, explain: | YES | NO |
| <hr/>  |     |    |
| 12. Do you clench or grind your teeth?   | YES | NO |
| 13. Does your jaw click or pop?  | YES | NO |
| 14. Have you experienced any pain or soreness in the muscles around your face or ears?               | YES | NO |
| 15. Do you have frequent headaches, neck aches or shoulder aches?                                    | YES | NO |
| 16. Does food get caught in your teeth?  | YES | NO |
| 17. Are any of your teeth sensitive to HOT, COLD, SWEETS or PRESSURE?                                | YES | NO |
| 18. Do your gums bleed or hurt?  | YES | NO |

19. How often do you brush your teeth? \_\_\_\_\_

20. How often do you floss? \_\_\_\_\_

21. Are you happy with your smile? YES NO

22. Do you feel your breath is offensive at times? YES NO

23. Have you ever had gum treatment or surgery? YES NO

24. Are you aware of tonsil stones? YES NO

25. Do you have any questions or concerns? YES NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

**PATIENT'S/ GUARDIAN'S SIGNATURE**

\_\_\_\_\_

**DATE** \_\_\_\_\_