

\_\_\_\_\_

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? \_\_\_\_\_

COMMENTS

- 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

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.

MED. ALERT

DENTAL HISTORY