

DENTAL HISTORY

1. Purpose of initial visit _____
2. Are you having dental problems at this time? YES NO
Explain _____
3. When was your last dental appointment? _____
What was done at that time _____
Previous dentist _____
4. When did you last have a set of x-rays taken? _____
5. Have you ever had a tooth removed? YES NO When? _____
Any complications? _____
6. Have missing teeth been replaced? _____ When? _____
How? Bridge Denture Partial Denture Implants
7. Have you made regular visits? _____
8. Do you clench or grind your teeth? YES NO
9. Have you experienced pain or soreness in the muscles of your face or around your ear? _____
10. Does food get caught between your teeth? _____
11. Do you have teeth that are sensitive to: Hot _____ Cold _____ Sweets _____ Pressure _____
12. How often do you brush your teeth? _____
13. Do your gums ever bleed or hurt when brushing? _____
14. Do you floss? _____
15. Has anyone ever told you your breath was offensive? _____

GETTING TO KNOW YOU

1. How did you select our office? _____ Is there someone we can thank for the referral? _____
2. Have you had any unpleasant experiences in the dental office? Anything about dentistry you dislike? Explain: _____
3. Do you feel nervous about having dental treatment? Not at all Slightly Moderately Extremely
4. How do you feel about getting/or maintaining a healthy mouth? _____
5. How do you feel about the appearance of your teeth? _____
6. If you could change anything about your smile, what would it be? _____
7. Indicate one or more of the following that are important to you. (Number in order of importance)

_____ Emergency treatment only	_____ My ability to chew and speak adequately
_____ Apprehension of dental treatment	_____ Long-term excellent dental & oral health
_____ Prevention or future dental problems	_____ Do not feel adequately informed about
_____ Esthetics, cosmetic dentistry	_____ dental & oral health to make a decision
8. Do you have other questions or concerns? _____
9. For Children:
Is this 1st visit to dentist YES NO
Does child eat between meals? YES NO
Does child eat lots of sweets? YES NO
Had child had cavities or fillings in past? YES NO
Have teeth been removed in past? YES NO
Is there a history of trauma, chips, injury to teeth? YES NO
Has child been recommended for orthodontics (braces)? YES NO
Have dental sealants been discussed with you? YES NO

I certify that the above information is complete and accurate

PATIENTS SIGNATURE (if child, signature of responsible person)

Date