PATIENT'S NAME: ____
(Last) (First) (MI)

1. Purpose of visit: ____________________
2. Are you aware of a problem? ____________________
3. When was your last dental visit? ____________________
4. What was done at that time? ____________________
5. Previous dentists name: ____________________
   Address: ____________________ Phone number: ____________________
6. When was the last time your teeth were cleaned? ____________________
7. When was the last time you had dental x-rays? ____________________
8. Have you ever been diagnosed or treated for periodontal disease (gum disease)? YES NO
9. Have you made regular visits for your dental cleanings? YES NO
10. Have you had orthodontic treatment (braces)? YES NO
11. Do you snore? YES NO
12. Have you lost any teeth or have any teeth been removed? YES NO
13. Have they been replaced? YES NO
14. How have they been replaced? FIXED BRIDGE PARTIAL DENTURE DENTURE IMPLANT
15. Are you unhappy with the replacement? YES NO
16. Have you ever had an unpleasant dental experience? YES NO
    If yes, please explain: ____________________
17. Do you clench or grind your teeth? YES NO
18. Does your jaw click or pop? YES NO
19. Have you experienced any pain or soreness in the muscles or your face or around your ear? YES NO
20. Do you have frequent headaches, neck aches or shoulder aches? YES NO
21. Does food get caught in your teeth? YES NO
22. Are any of your teeth sensitive to: HOT COLD SWEETS PRESSURE
23. Do your gums bleed or hurt? YES NO
24. How often do you brush your teeth? ____________________ Floss? ____________________
25. What type of toothbrush do you use? SOFT MEDIUM HARD ELECTRIC
26. If you use an electric toothbrush, which one do you use? ____________________
27. Are any of your teeth loose, tipped, shifted or chipped? YES NO
28. How do you feel about your teeth in general? ____________________
    ____
29. Do you feel your breath is offensive sometimes? YES NO
30. Are you self-conscious about your smile? YES NO
31. Do you wish your teeth were whiter? YES NO
32. Do you dislike the shape of your teeth? YES NO
33. Do you have spaces between your teeth that you don't like? YES NO
34. Do you have old fillings or dental work that you don't like looking at? YES NO

Please list any other questions or concerns that you have about your mouth or oral health:
____
____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S (OR GUARDIAN'S) SIGNATURE ____________________ DATE ____________________

DENTIST'S SIGNATURE ____________________ DATE ____________________

DENTAL HISTORY