

# PATIENT DENTAL HISTORY

## Patient's Dental History

What is your primary reason for seeking dental care?

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### Previous Dentist Information

Dentist's Full Name: \_\_\_\_\_

City, State and ZIP: \_\_\_\_\_

Month and Year of Last Visit: \_\_\_\_\_

What was done at your last visit? \_\_\_\_\_

Date of Last full mouth x-rays: \_\_\_\_\_

Reason for leaving previous dentist: \_\_\_\_\_

How often do you visit the dentist?  Annual Check Up  Twice a Year Check Up  
 Only when I have a problem  Other

### Please choose the appropriate answer

Are you nervous about receiving dental treatment?  Yes  No

Do you gag easily?  Yes  No

Have you had previous problems with dental care?  Yes  No

If so, please explain?

Are your teeth sensitive to hot, cold, pressure or sweets?  Yes  No

Do you have problems with teeth/fillings breaking?  Yes  No

Are you aware of an uncomfortable bite?  Yes  No

Do your gums feel tender and/or bleed?  Yes  No

Does food catch between your teeth?  Yes  No

Have you had periodontal (gum) treatments?  Yes  No

Do you get sores in or around your mouth?  Yes  No

Do you have regular headaches, earaches or neck pains?  Yes  No

Do you grind or clench your teeth?  Yes  No

Do you hear a "clicking" sound when you open/close your mouth?  Yes  No

Does your jaw ever get "stuck?"  Yes  No

Do you have a Temporomandibular (TMJ) jaw disorder?  Yes  No

Are you missing teeth that have not been replaced?  Yes  No

Have you had excessive bleeding after an extraction?  Yes  No

Do you take any Bisphosphonate medication such as Fosamax, Boniva, Actonel, Aredia or Zometa?  Yes  No

Have you had mouth sores that take long to heal?  Yes  No

Do you have any dental implants?  Yes  No

Do you wear dentures (partials or full)?  Yes  No

Do you have any crowns (caps) or bridges?  Yes  No

Do you chew tobacco?  Yes  No

Do you have a dry mouth?  Yes  No

Are you unhappy with the appearance of your teeth?  Yes  No

Would you like your smile to look better?  Yes  No

Would you like whiter teeth?  Yes  No

Do you regularly use dental floss?  Yes  No

Do you brush at least once daily?  Yes  No

Is there anything else that you would like us to know?

I authorize the use of my radiographs [x-rays] and/or photographs for educational and promotional use in seminars, publications and the dental office web site.  Yes  No

I hereby certify that the foregoing information is accurate and complete and that I will notify the office of any changes in a timely manner. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in completion of this form.

Signature: \_\_\_\_\_