PATIENT'S NAME_____

Last First Initial

Please comment on all yes answers in this space below.

1. Reason for today's visit:_____
2. How long since your last dental visit?_____
3. What was done at that time? _____
4. Were dental x-rays taken? YES NO
5. When was the last time your teeth were cleaned?_____
6. Previous dentist's name _____

   Address_____

   _____ Phone _____
7. Have any of your teeth been lost or removed? YES NO
8. If yes, have they been replaced? YES NO
9. Do you clench or grind your teeth? YES NO
10. Are your teeth sensitive to hot _____ cold _____ sweets _____ pressure_____
11. Does your jaw click or pop? YES NO
12. Do you have frequent headaches, neck aches or shoulder aches? YES NO
13. Have you had any orthodontic treatment? YES NO
14. Does food frequently get caught between your teeth? YES NO
15. Do your gums bleed or hurt? YES NO
16. Are any of your teeth loose, tipped or shifted? YES NO
17. Do you feel your breath is routinely offensive? YES NO
18. Have you ever had gum treatment or surgery? YES NO

    If yes, what was done and when? _____
19. How often and when do you brush your teeth?_____
20. Do you use dental floss? YES NO
21. How do you feel about your teeth in general?_____
22. Have you had any unpleasant dental experiences or is there anything we have not covered in this form? YES NO
23. Is there anything else we should know about your health that we have not covered in this form? YES NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S SIGNATURE _____ DATE_____

DENTIST'S SIGNATURE _____ DATE_____

DENTAL HISTORY