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(800) 243-4675

welcome

PATIENT NUMBER

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? ______________________________

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. How often do you brush your teeth? ______________ When? ______________
23. Do you use dental floss? . . . . YES NO
How often? ______________________________
24. Are any of your teeth loose, tipped, shifted or chipped? . . . . YES NO
25. Are you unhappy with the appearance of your teeth? . . . . YES NO
26. How do you feel about your teeth in general? ______________________________
27. Do you feel your breath is offensive at times? . . . . YES NO
28. Have you ever had gum treatment or surgery? . . . . YES NO
What? ______________________________
Where? ______________________________
When? ______________________________
29. Have you had any orthodontic work? ______________________________
30. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike? ______________________________
31. Do you have any questions or concerns? . . . . YES NO

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

Form No. T150DH

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