PATIENT:_____

LAST FIRST MIDDLE SUFFIX(JR., SR.) DATE ACCOUNT #

DENTAL HISTORY

Please circle YES or NO, and provide detail where applicable:

1. What is/are your major dental concern(s):

   _____

   _____

   _____

2. Date of your last visit to a Dentist: _____ Date of your last dental x-rays _____
3. When was the last time your teeth were cleaned? _____

YES NO 4. Have you always made regular dental visits?

*IF YOU DO NOT HAVE ANY NATURAL TEETH (I.E., WEAR FULL DENTURES), PLEASE SKIP TO QUESTION #11:

YES NO 5. Do you use dental floss? _____

YES NO 6. Do you brush your teeth daily? _____

YES NO 7. Do your gums bleed when you brush your teeth or when you eat? _____

YES NO 8. Does food or dental floss catch between your teeth? _____

YES NO 9 . Are there spaces between your teeth now where there were none before? _____

YES NO 10. Do you have any pain or sensitivity with any of your teeth?_____

_____

YES NO 11. Are you happy with the appearance of your teeth? _____

If no, please explain: _____

YES NO 12. Would you be interested in changing (lightening) the color of your teeth? _____

YES NO 13. Are you happy with the function and comfort of your teeth? _____

If no, please explain: _____

YES NO 14. Have you always had good experiences with dental office visits? _____

If no, please explain: _____

YES NO 15. Have you experienced an unusual reaction to dental medication or anesthetic? _____

YES NO 16. Have you ever had prolonged bleeding or other complications following dental treatment? _____

If yes, please explain: _____

YES NO 17. Have you ever had gum (periodontal) treatment or surgery? _____

YES NO 18. Have you ever had any injury to your teeth, jaws or face? _____

If yes, please explain: _____

YES NO 19. Do you wear dentures (complete or partial)? _____

If yes, how long have you had them: _____

YES NO 20. Do you experience pain or clicking in your jaw joints? _____

YES NO 21. Do you clench or grind your teeth? _____

YES NO 22. Are there any sores or growths in your mouth? _____

YES NO 23. Are you worried about receiving dental treatment? _

24. Ideally, what would be your expectations of dental treatment? _____

_____

_____

_____

********Please list all dentists or dental specialists you have seen in the past: _____

_____

_____

SIGNATURE OF PATIENT: To the best of my knowledge, the answers I have given are accurate and complete. I agree to report any changes in my dental status to the dentist at the earliest possible time. I give permission to the dentist to obtain any additional information regarding my medical/dental history needed to provide me the best dental treatment possible.

PERSON COMPLETING THIS FORM: Signature _____ DATE _____

If other than patient, indicate relationship: _____

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