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Dental History Form

What is the purpose for your appointment?

- ◯ To become a patient
- ◯ Emergency
- ◯ Consult
- ◯ Second opinion

Is this your very first Dental visit?

* ◯ Yes ◯ No

When was the last time you were at a dental office?

Do you remember what was done at that appointment?

Do you have any X-rays that are less than 2 years old?

* ◯ Yes ◯ No

Have you made regular visits for dental check-ups?

* ◯ Yes ◯ No

Have you lost any teeth, or have had any teeth removed?

* ◯ Yes ◯ No

Have the missing teeth been replaced?

◯ Yes ◯ No

If teeth have been replaced, is it with:

- ☐ Implants
- ☐ Fixed bridge
- ☐ Removable partial
- ☐ Denture

Are you happy with the replacement?

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◯ Yes ◯ No

If the missing teeth are not replaced, would you like to know about replacements?

◯ Yes ◯ No

Do you clench or grind your teeth?

* ◯ Yes ◯ No

Does your jaw click or pop?

* ◯ Yes ◯ No

Are any of the muscles of your face or jaw sore or hurt?

* ◯ Yes ◯ No

Do you get frequent headaches, backaches or shoulder aches?

* ◯ Yes ◯ No

Are you aware of any Dental problems?

* ◯ Yes ◯ No

Do you have any complications with any previous dental treatment?

* ◯ Yes ◯ No

If you have complications, what is the nature of the problem?

Do you have any teeth that are sensitive to any of the following?

☐ Hots ☐ Colds ☐ Sweets ☐ Biting ☐ Pressure

Do you have any teeth that are:

☐ chipped ☐ loose ☐ Tipped ☐ shifted

Do you find that your gums bleed, hurt or are swollen?

* ◯ Yes ◯ No

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Have you had any gum (periodontal) treatment or surgery?

* ◯ Yes ◯ No

Do you find your breath offensive?

◯ Yes ◯ No

Response Date: