PATIENT NUMBER

Patient's Name ______________________________

Last | First | Inital | Date of Birth

1. Purpose of initial visit ______________________________

2. How long since your last visit? ______________________________
3. What was done last time ? ______________________________

4. Previous dentist's name ______________________________
   Address: ______________________ Tel. ______________
5. When was th last time your teeth were cleaned? ______________
6. Have you lost any teeth or have any teeth been removed? .... YES☐ NO☐
   Why?: ______________________________

COMMENTS

CHECK THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER, PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER QUESTION.

7. How have they been replaced?.. YES☐ NO☐
8. Are you unhappy with the replacement?.................................... YES☐ NO☐
   If yes, explain ______________________________
9. Have you ever had any problems or complications with previous dental treatment?.. YES☐ NO☐
   If yes, explain ______________________________
10. Do you clench or grind your teeth?.. YES☐ NO☐
11. Does your jaw click or pop?... YES☐ NO☐
12. Have you experienced any pain or soreness in the muscles or your face or around your ear?... YES☐ NO☐
13. Do you have frequent headaches, neckaches or shoulder aches ?................ YES☐ NO☐
14. Are any of your teeth sensitive to : ☐ Hot? ☐ Cold? ☐ Sweet? ☐ Pressure?
15. Do your gums bleed or hurt?... YES☐ NO☐
    When? ______________________________
16. How often do you brush your teeth? ______________ When? ______________
17. Do you use dental floss?.. YES☐ NO☐
    How often? ______________________________
18. Are any of your teeth loose, tipped, shifted or chipped?..................... YES☐ NO☐
19. Are you unhappy with the appearance of your teeth?.......................... YES☐ NO☐
20. Do you feel your breath is offensive at times?.............................. YES☐ NO☐
21. Have you ever had gum treatment or surgery?................................ YES☐ NO☐
22. Have you had any orthodontic work? ______________________________
23. Have you had any unpleasant dental experience or is there anything about dentistry that you strongly dislike? ______________________________
24. Do you have any questions or concerns?.................................... YES☐ NO☐
    Explain ______________________________
25. Do you want to tell the dentist any information which might help him/her in treating you ______________________________

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE ______________________ DATE ______________

DENTIST'S SIGNATURE ______________________ DATE ______________

ANEST. ☐

DENTAL HISTORY

MED. ALERT ☐