PATIENT DENTAL HISTORY

Patient's name_____ Date of Birth_____

Reason for this visit_____

Last dental visit (date) _____ Treatment provided at that time_____

Frequency of dental visits_____ Previous dentist (name and location) _____

Have you had a complete series of dental films/x-rays taken? _____ Where?_____

When? _____ Can we request these be sent to this office?_____

Please indicate Yes (Y) or No (N) to the following:

Do your gums bleed while brushing or flossing? ____

Are your teeth sensitive to hot or cold? ____

Are your teeth sensitive to sweets or sour? ____

Do you feel pain in any of your teeth? ____

Do you have any sores or lumps in or near your mouth? ____

Have you ever had any head, neck or jaw injuries? ____

Have you ever experienced any of the following problems in your jaw?

- Clicking ____
- Pain (joint, ear or side of face) ____
- Difficulty in opening/closing ____
- Difficulty in chewing ____

Do you have frequent headaches? ____

Do you clench or grind your teeth? ____

Do you bite your lips/cheeks frequently? ____

Have you notices any loosening of your teeth? ____

Does food get caught between your teeth? ____

Have you had periodontal (gum) treatment? ____

Have you received oral hygiene instruction for the care of your teeth and gums? ____

Have you difficult extractions before? ____

Have you had prolonged bleeding following extractions before? ____

Do you wear dentures or partials? ____

If yes, date of placement_____

Do you have dental implants? ____

If yes, date of placement_____

Have you had orthodontic treatment? ____

If yes, date of completing__ _____

Have you had treatment from a dental specialist? ____

If yes, what type?_____

Additional comments or concerns? _____

_____

_____

Dentist's comments_____

_____

_____

_____ _____ _____ _____

Patient's/Parent's/Guardian's signature | Date | Dentist's signature | Date