

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? \_\_\_\_\_

COMMENTS

Large empty box for patient comments.

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

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

DENTIST'S SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

ANEST. box

MED. ALERT box

DENTAL HISTORY