Welcome

Patient's Name ____
Last First Initial Age 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 the time of last dental visit:_____________________________________
5. Previous Dentist's Name: ______________________ Address:________________________
   Phone number: ______________________________
6. When was the last time your teeth were cleaned:____________________
   CIRCLE THE APPROPRIATE ANSWER. IF YOU DO NOT KNOW THE CORRECT ANSWER, PLEASE WRITE "DO NOT KNOW" ON THE LINE AFTER QUESTION.
7. Have you and do you maintain regular 6 month cleanings and check-up appointments? Yes / No
8. Were dental x-rays taken? Yes / No
9. Have you lost any teeth or have any teeth been removed? Yes / No
10. Have they been replaced? Yes / No
11. How have they been replaced?
    Fixed bridge____________________________ Age: ________________
    Removable bridge ______________________ Age: ________________
    Denture ______________________________ Age: ________________
12. Are you unhappy with the replacement? Yes / No
    If yes, please explain: ____
13. Would you like to know about permanent replacements? Yes / No
14. Have you ever had any problems or complications with previous dental treatments Yes / No
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
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? ____
    When? ____
    Where? ____
29. Have you had any orthodontic work? ____

Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike?

30. Do you wake feeling not fully rested? Yes / No
31. Do you snore or have been told you snore? Yes / No
32. Do have or been diagnosed with Sleep Apnea Yes / No

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT SIGNATURE/GUARDIAN: ______________________________________ DATE:__________

DENTAL HISTORY