

Dental History

Date: _____

Patient Name: _____

Last

First

MI

Date of Birth

Do you have a specific dental problem today? Y N

If yes, please explain: _____

Do you have dental examinations/cleanings on a routine basis? Y N

If yes, list the date of your last dental examination/cleaning: _____

How often do you brush your teeth? _____

Do you floss on a routine basis? Y N

If yes, how often: _____

Do you like your smile? Y N

If no, please state why: _____

Do you think you have active tooth decay or gum disease? Y N

Have you ever had gum treatment or gum surgery? Y N

If yes, when?: _____ where?: _____

Do your gums bleed? Y N

Do you have any loose teeth? Y N

Do you want to keep your remaining teeth? Y N

Do you have clicking, popping, or discomfort in the jaw joints? Y N

Do you grind or clench your teeth? Y N

Do you smoke or chew tobacco? Y N

Do you have any tongue or lip piercings? Y N

Have you ever had or do you presently wear braces? Y N

If yes, do you wear a retainer? Y N

Do you presently wear a removable partial or denture? Y N

If yes, are you unhappy with them? Y N

Would you like to know about other teeth replacement alternatives? Y N

Have you ever had any complications following dental treatment? Y N

If yes, please explain: _____

Name of your previous dentist (optional): _____

Date of your last full mouth x-rays (16 small films or panoramic): _____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S OR GUARDIAN'S SIGNATURE: _____

DENTIST'S SIGNATURE: _____

Medical History Update (For Office Use Only)

Date: _____ Comments: _____ Initials: _____

Date: _____ Comments: _____ Initials: _____

Date: _____ Comments: _____ Initials: _____

Date: _____ Comments: _____ Initials: _____

Date: _____ Comments: _____ Initials: _____