all smiles.
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DENTAL HISTORY

Patient name _____ Referred by _____

Previous dentist _____ For how long? _____

Most recent dental exam _____ Most recent dental x-ray _____

Most recent dental treatment _____

How often do you have your teeth cleaned? ○ 3 months ○ 4 months ○ 6 months ○ 1 year or longer

YOUR IMMEDIATE DENTAL CONCERN(S)?

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

Unhappy with the appearance of your teeth?	○ YES	○ NO	Unpleasant taste or odor in your mouth?	○ YES	○ NO
Unfavorable dental experiences?	○ YES	○ NO	Dry mouth, throat, and or eyes?	○ YES	○ NO
Dental fears?	○ YES	○ NO	Jaw problems (temporomandibular joint)?	○ YES	○ NO
Problems with effectiveness or bad reactions to dental anesthetic?	○ YES	○ NO	Difficulty opening your mouth widely?	○ YES	○ NO
Orthodontic treatment (braces)?	○ YES	○ NO	Stiff neck muscles?	○ YES	○ NO
Periodontal (gum) treatment?	○ YES	○ NO	Awaken with an awareness of your teeth or jaws?	○ YES	○ NO
Bleeding gums?	○ YES	○ NO	Tension headaches?	○ YES	○ NO
Avoid brushing any part of your mouth?	○ YES	○ NO	Clench or grind your teeth?	○ YES	○ NO
Part of your mouth sensitive to temperature?	○ YES	○ NO	Jaw clicking or popping?	○ YES	○ NO
Sore teeth?	○ YES	○ NO	Lost any teeth?	○ YES	○ NO
Burning sensation in your mouth?	○ YES	○ NO	Sweat or tremble alot during examination?	○ YES	○ NO
Difficulty swallowing?	○ YES	○ NO	Strange people or places make you afraid?	○ YES	○ NO

SUPPLEMENTAL DENTURE HISTORY:

If you are wearing a partial or complete artificial denture, please complete the following:

Has your present denture been relined? ○ YES ○ NO

If yes, when (month/year) _____

Is your present denture a problem? ○ YES ○ NO

If yes, describe _____

Satisfied with the appearance? ○ YES ○ NO

Satisfied with the comfort? ○ YES ○ NO

Satisfied with the chewing ability? ○ YES ○ NO

When did you receive your first partial or complete denture? _____

How long have you worn your present denture? _____

SIGNATURE _____ DATE _____

NOTE: If remitting electronically via email or fax, patient will sign and date at first office visit.

EMAIL PRINT SAVE to disk CLEAR INFO