Patient's Name____
Last First Initial Date of Birth

Purpose of initial visit?________________________________

How long since your last dental visit?___________________________

What was done at that time?____________________________________

When was the last time your teeth were cleaned?_____________

When were dental x-rays taken?_________________________

Previous Dentist____

Address____

COMMENTS

(Circle the appropriate answer)

YES NO **Have you lost any teeth or have teeth been removed?**
YES NO **Do you wear: dentures_____ fixed bridge____________**
partial ______removable bridge_______
YES NO **Are you satisfied with the replacement?**
YES NO **Are you interested in replacing missing teeth?**
YES NO **Do you clench or grind your teeth?**
YES NO **Does your jaw click or pop?**
YES NO **Any pain or soreness in the muscles of your face or around your ear?**
YES NO **Do you have frequent headaches, neck aches or shoulder aches?**
YES NO **Does food get caught between your teeth?**
YES NO **Do your gums bleed or hurt?**
YES NO **Are any of your teeth loose, tipped or shifted?**
YES NO **Are any of your teeth sensitive to:**
hot ——— cold ——— sweet ——— pressure ———
YES NO **Have you ever had gum treatment or surgery?**

Where ____

When ____
YES NO **Have you ever had any problems or complications with previous dental treatment?**
Explain ____

YES NO **Are you satisfied with the appearance of your teeth?**
What corrections would you like to have made? ______________________________

____

SIGNATURE_________________________________ **DATE** ______________________

DENTAL HISTORY