DENTAL HISTORY

How long since your last dental visit?
☐ Less than 6 mths ☐ 6 - 12 mths ☐ 1 -2 years ☐ 2 - 5 years ☐ 5+ years

How long since your last complete dental examination?
☐ Less than 6 mths ☐ 6 - 12 mths ☐ 1 -2 years ☐ 2 - 5 years ☐ 5+ years

How long since your last full mouth series of X-Rays?
☐ Less than 6 mths ☐ 6 - 12 mths ☐ 1 -2 years ☐ 2 - 5 years ☐ 5+ years

Name of your previous dentist: ____________________

City ____________________ State _________ Phone Number (____)____________________

Reason for leaving previous dentist: ____________________

Are you having any problems with your teeth at present? (If yes, please describe): ____________________

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Please check Yes or No to the following questions.

Yes		No	Yes		No
☐	Has your dental care been regular in the past 5 years?	☐	☐	Are your jaws or teeth sore when you awake from sleep ?	☐
☐	Is your dental health poor?	☐	☐	Do you have headaches, earaches, or neck pain?	☐
☐	Do you think you will lose all of your teeth soon?	☐	☐	Have you lost any teeth other than wisdom teeth?	☐
☐	Have you had bad experiences in the past?	☐	☐	Have lost teeth been replaced?	☐
☐	Are you apprehensive about dental treatment?	☐	☐	Has tooth replacement been recommended?	☐
☐	Are you dissatisfied with any past dental treatment?	☐	☐	Do you have loose, tipped or shifted teeth?	☐
☐	Have you had any periodontal treatments?	☐	☐	Have you worn braces on your teeth?	☐
☐	Has periodontal treatment ever been recommended?	☐	☐	Have you had any of the nerves of teeth removed?	☐
☐	Are you troubled with bad breath?	☐	☐	Have any teeth darkened from nerve removal?	☐
☐	Does food usually wedge between certain teeth?	☐	☐	Have any teeth discolored from fillings?	☐
☐	Do your gums bleed or feel tender or irritated?	☐	☐	Does the color of your teeth bother you?	☐
☐	Are you aware of grinding or clenching of your teeth?	☐	☐	Do you have problems with fillings or teeth breaking?	☐
☐	Are you happy with the appearance of your teeth?	☐	☐	Do you regularly use dental floss?	☐
☐	Are your teeth sensitive to Hot, Cold, Sweets, or Pressure?	☐	☐	Would you like us to help you learn proper methods of home care?	☐

Please rank from 1 to 4 the order in which they would keep you from having dental treatment:
Fear of pain _____ Cost of treatment _____ Lack of concern _____ Missing work time _____

How do you feel about your teeth? ____________________

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Is there any other dental information that you feel we should be made aware? ____________________

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