PATIENT NUMBER

PATIENT NAME: M ☐ F: ☐ _____ DATE: _____ Day/ Month/Year

BIRTH DATE: _____ Day/Month/Year

Please answer all questions with ✔ or ✘

	YES	NO
1. Are you having pain or discomfort at this time?	☐	☐

2. Do you have any of the following?

	YES	NO		YES	NO		YES	NO
Painful Gums	☐	☐	Grinding / Clenching	☐	☐	Mouth Growths	☐	☐
Swollen Gums	☐	☐	Lip / Cheek Biting	☐	☐	Difficult Jaw Opening	☐	☐
Bleeding Gums	☐	☐	Nail / Pen Biting	☐	☐	Difficult Jaw Closing	☐	☐
Loose Teeth	☐	☐	Mouth Breathing	☐	☐	Gag Easily	☐	☐
Sensitive Teeth	☐	☐	Mouth Sores	☐	☐			

3. How frequently do you see your dentist?
   3 months ☐ 4 months ☐ 6 months ☐
   9 months ☐ Yearly ☐ When needed ☐

4. Last dental visit _____ Last scaling (Cleaning) _____ Last X-rays _____

5. Name of previous Dentist _____

	YES	NO
6. Have you been given oral hygiene instructions? Brush ☐ Floss ☐ Others ☐	☐	☐
7. Do you feel any of your fillings? Rough ☐ High ☐ Food catching when eating ☐	☐	☐
8. Do you chew primarily on one side of your mouth? Right ☐ Left ☐	☐	☐
9 Do you have any dental implants?	☐	☐
10. Does your jaw ever crack or pop?	☐	☐
11. Does your jaw ever lock open?	☐	☐
12. Did you ever have any blows to your jaw?	☐	☐
13. Would you like to discuss options to change the appearance of your smile?	☐	☐
14. Have you ever been advised to take antibiotics before dental appointments for medical reasons?	☐	☐
15. Have you ever had a problem with bad breath?	☐	☐
16. Do you have any questions or concerns about your teeth?	☐	☐
17. Is there a dental problem you would like taken care of today?	☐	☐
18. Have you ever had any treatment by a dental specialist? Reason: When:	☐	☐

19. How would you rate your current dental health?
    Excellent ☐ Good ☐ Fair ☐ Poor ☐ Not Sure ☐

DOCTOR'S COMMENTS

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. I consent to your obtaining, from other practitioners who are currently treating me or have treated me, such further information as maybe necessary for providing me with proper dental treatment and care.

PATIENT'S SIGNATURE/: _____ DATE: _____ D.D.S: _____
PARENT OR GUARDIAN

HEALTH ALERT

Dental History