Dental History Form

Name ____

Previous Dentist ______________________________ How long? ______________________

Last dental exam _____________________________ Last dental treatment _______________

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

How would you rate your past care? ____

What is your immediate dental concern? ____

Please check if you have, or ever had the following:

- ☐ Unhappy with appearance of your teeth.
- ☐ Unfavorable dental experiences.
- ☐ Dental fears.
- ☐ Preference for no dental anesthetic.
- ☐ Problems with effectiveness or bad reactions to dental anesthetic.
- ☐ Orthodontic treatment (braces) When? _____________
- ☐ Periodontal (gum) treatment.
- ☐ Bleeding gums.
- ☐ Loose teeth.
- ☐ Avoid brushing any part of your mouth.
- ☐ Part of your mouth is sensitive to temperature or sweets.
- ☐ Sore teeth.
- ☐ A burning sensation in your mouth.
- ☐ Difficulty swallowing.
- ☐ An unpleasant taste or odor in your mouth.
- ☐ Jaw problems (temporomandibular joint)
- ☐ Difficulty opening your mouth widely.
- ☐ Stiff neck muscles.
- ☐ Awaken with an awareness of your teeth or jaw.
- ☐ Lost any teeth.
- ☐ History of trauma to teeth or jaw.

Supplemental Denture History:

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

	(Please circle Yes or No)	
Has your present denture been relined? When? ____________________	Yes	No
Is your present denture a problem? Describe: ____________________	Yes	No
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? ____________________

I agree to allow the release of any records deemed necessary, including periodontal charting and x-rays, to my representative insurance company or companies.

Patient's Signature ____ Date _______________

Dentist's Remarks ____

Rev:_________________

Thank You