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