

Patient Name _____
last first m.i.

1. Chief complaint or reason for visit _____

2. Do you feel nervous about having dental treatment? YES NO
If Yes: Somewhat Moderately Extremely

3. Have you ever had a bad experience in a dental office? YES NO

4. Date of last: Dental Visit _____ Dental X-Rays _____
Previous cleaning interval: 3 mos. 4 mos. 6 mos.

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

6. Do you have or have you had any of the following? (Please circle)
Teeth sensitive to: HOT / COLD / SWEETS / BITING / CHEWING
Bleeding or swollen gums Popping or clicking of jaw joints
Bad taste or mouth odor Facial or jaw pain
Loose or separating teeth Frequent headaches
Partial or complete dentures Difficulty swallowing or chewing
Gum surgery Braces (Orthodontia)
Implants Sleep apnea

7. How often do you brush? _____ Floss? _____

8. What texture brush do you use? SOFT MEDIUM HARD

9. List any other cleaning devices you use regularly (i.e. rinses, toothpicks, irrigation sprays, etc.)

10. Do you gag easily? YES NO

11. Do you smoke? How much? _____ YES NO

12. Do you use chewing tobacco? What type and how much? _____ YES NO

13. Is it important to you to keep your teeth? YES NO

14. Are you satisfied with the appearance of your teeth? YES NO

15. Reason for leaving last dentist: _____

16. Please add anything else that you feel is important: _____

Patient Signature

Date

DENTAL HISTORY