Dental History

Print Form

Patient's Name: _____ Date: _____

What is your estimate of your dental health? ◯ Good ◯ Fair ◯ Poor

What specific dental concerns do you have now? _____

How long ago was your last dental visit?
And what was the treatment? _____

Please mark any questions that you would answer 'YES".

- ☐ Are you here today because of an emergency/pain?
- ☐ Are you interested in "Comprehensive" care?
- ☐ Are you apprehensive about dental care?
- ☐ Have you had problems with previous dental treatment?

- ☐ Do you have sore, tender or bleeding gums?
- ☐ Have you had gingivitis or periodontal disease?
- ☐ Do you have your teeth cleaned more than twice a year?
- ☐ Have you seen a periodontal specialist for treatment?

- ☐ Are your teeth sensitive? And to what? (Check below)
  - ☐ Hot or cold foods/liquids?
  - ☐ Biting?
  - ☐ Other?

- ☐ Are you missing teeth other than wisdom teeth?
- ☐ Do you wear partials or dentures?
- ☐ Do you have any dental implants?
- ☐ Does food catch in your teeth? Any loose teeth?

- ☐ Have you had orthodontics?
  - ☐ Still wearing retainers?

- ☐ Do you clench or grind your teeth frequently?
- ☐ Do you wear a nightguard/ biteguard?
- ☐ Do you wear a sports guard when playing sports?

- ☐ Have you been diagnosed with a Tempormandibular (jaw) Disorder (TMJ or TMD)?
- ☐ Do you have headaches or jaw symptoms on wakening?
- ☐ Do you have pain in your face, jaw joint, neck or temples?
- ☐ Have you had any jaw or facial trauma?

- ☐ Is there anything you would change about your teeth?
  - ☐ Color?
  - ☐ Shape?
  - ☐ Spaces?
  - ☐ Alignment?
  - ☐ Other?

How often do you brush and floss? _____

What statement best describes the treatment you are seeking?

- ◯ Just want to avoid pain.
- ◯ Want to keep my teeth functional and healthy.
- ◯ Want to keep my teeth functional, healthy and good looking.

Anything else we should know? _____

Doctor's Notes:

Reset Form