DENTAL HISTORY

1. Purpose of initial visit .....
2. Are you having any dental problems at this time? ..... ☐ Yes ☐ No
   Explain .....
3. When was your last dental appointment? .....
   What was done at that time? .....
   Previous dentist .....
4. When did you last have a set of dental x-rays taken? .....
   Any x-rays taken recently? .....
5. Have you ever had a tooth removed? ☐ Yes ☐ No When? .....
   Any complications? .....
6. Have missing teeth been replaced? ..... When? .....
   How? ☐ Bridge ☐ Denture ☐ Partial Denture ☐ Implants
7. Have you made regular visits? .....
8. Do you clench or grind your teeth? ..... ☐ Yes ☐ No
   Does your jaw click or pop in front of the ears? .....
9. Have you experienced pain or soreness in the muscles of your face or around your ears? ..... ☐ Yes ☐ No
10. Does food get caught between your teeth? ..... ☐ Yes ☐ No
11. Do you have teeth that are sensitive to ☐ Hot ☐ Cold ☐ Sweets ☐ Pressure
12. How often do you brush your teeth? ..... When? .....
13. Do your gums ever bleed or hurt when brushing? .....
14. Do you floss? ..... How often? .....
15. Has anyone ever told you your breath was offensive? .....

GETTING TO KNOW YOU

1. How did you select our office? ..... is there someone we can thank for the referral? .....
2. Have you had any unpleasant experiences in the dental office? Anything about dentistry you dislike? Explain: .....
3. Do you feel nervous about having dental treatment? ☐ Not at all ☐ Slightly ☐ Moderately ☐ Extremely
4. How do you feel about getting and/or maintaining a healthy mouth? .....
5. How do you feel about the appearance of your teeth? .....
6. If you could change anything about your smile, what would it be? .....
7. Indicate one or more of the following that are important to you. (Number in order of importance)

   _____ Emergency treatment only
   _____ Apprehension of dental treatment
   _____ Prevention of future dental problems
   _____ Esthetics, cosmetic dentistry
   _____ My ability to chew and speak adequately
   _____ Long-term excellent dental & oral health
   _____ Do not feel adequately informed about dental & oral health to make a decision

8. Do you have other questions or concerns? .....

9. **For Children:**
   Is this 1st visit to dentist? ..... ☐ Yes ☐ No
   Does child eat between meals? ..... ☐ Yes ☐ No
   Does child eat lots of sweets? ..... ☐ Yes ☐ No
   Has child had cavities or fillings in past? ..... ☐ Yes ☐ No
   Have teeth been removed in past? ..... ☐ Yes ☐ No
   Is there a history of trauma, chips, injury to teeth? ..... ☐ Yes ☐ No
   Has child been recommended for orthodontics (braces)? ..... ☐ Yes ☐ No
   Have dental sealants been discussed with you? ..... ☐ Yes ☐ No

I certify that the above information is complete and accurate

PATIENT'S SIGNATURE (If child, signature of ɔnsible person) DATE