



Patient's Name _____ Date of Birth _____
Last First Initial

If Child: Parent's Name _____

Previous Dentist's name, address, tel. _____

Date of last dental visit _____ Last dental cleaning _____ Last Full Mouth X-rays _____

How often do you brush your teeth? _____ How often do you floss? _____

Have you made regular visits to the dentist? YES NO

How often: _____

Have you lost any teeth or have any teeth been removed? YES NO

Why? _____

Have they been replaced? YES NO

How have they been replaced?

Fixed bridge _____ Age _____

Removable bridge _____ Age _____

Denture _____ Age _____

Implant _____ Age _____

Are you unhappy with the replacement? YES NO

If yes, explain _____

Would you like to know about permanent replacements? YES NO

Have you ever had any problems or complications with previous dental treatment? YES NO

If yes, explain _____

Do you clench or grind your teeth? YES NO

Does your jaw click or pop? YES NO

Do you have frequent headaches, neck aches or shoulder aches? YES NO

Does food get caught in our teeth? YES NO

Are your teeth sensitive to: Hot? Cold? Sweets? Pressure?

Do your gums bleed or hurt? YES NO

When? _____

Are any of your teeth loose, tipped, shifted or chipped? YES NO

Do you feel your breath is offensive at times? YES NO

Have you ever had gum treatment or surgery? YES NO

When? _____ Where? _____

Have you had any orthodontic work? _____

Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike? _____

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S OR GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____