Dental History for New Patient

To help us provide you with the best possible care, please answer all questions on this dental history form. All information is completely confidential.

Last Name: ______________________ First Name: ____________________ Birthdate: ____________

Reason for today's ____

Date of last dental visit ____

Date of last cleaning ____

Date of last x-rays ____

Type of x-rays ____

How often do you brush your teeth? ____

Floss ____

Have you ever had any serious problems with previous dental work?

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Are you apprehensive about dental treatment? ____

We offer sedation for dentistry — would you be interested? ____

Do you have any of the following dental conditions?

Y	N		Y	N	
		Bleeding Gums?			Do your gums hurt?
		Have you noticed any loose teeth?			Change in your bite?
		Does food impact between your teeth?			Do you clench or grind your teeth?
		Do you have tired jaws or jaw pain?			Have you had braces and/or a retainer?
		Do you have tooth pain?			Teeth sensitive to hot, cold and/or sweets?
		Do you experience dry mouth?			Have you ever had periodontal (gum) treatment?
		Do you snore?			Sleep Apnea or gasping for air when sleeping?
		Do you have any bridge work, implants?			Are you satisfied with the appearance of your teeth?
		Do you want to bleach your teeth?			Do you have any removable dental work?
		Do you have a bite/night guard, bleach trays?			Do you hear clicking/popping when you chew?
		Oral habits like chewing pens, lips, cheeks?			Other dental problems?

Unusual reaction to dental injections? ____

Date: ____________

Signature: ____