

# Dental Health History Form

Today's Date \_\_\_\_\_

Patient Name: First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_ Nickname \_\_\_\_\_

What are your goals in coming to our practice today? \_\_\_\_\_

What is important to you in a dentist or dental practice? \_\_\_\_\_

What has been your experience with the dentist in the past? \_\_\_\_\_

Date of last radiographs (x-rays) and exam \_\_\_\_\_

Date of last hygiene continuing care appointment (cleaning or periodontal maintenance) \_\_\_\_\_

Former Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Address: Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

If you left your previous dentist, what are the reasons? \_\_\_\_\_

Have you had problems with prior dental treatment? \_\_\_\_\_

Are you experiencing any pain now?  Yes  No

If yes, please describe \_\_\_\_\_

Have you ever been pre-medicated for dental treatment?  Yes  No

If yes, why? \_\_\_\_\_

Have you been anxious about having dental treatment?  Yes  No

If yes, would you be comfortable sharing why? \_\_\_\_\_

Would you like to discuss this concern with the doctor to learn about your relaxation options? \_\_\_\_\_

What concerns do you currently have with your oral health or smile? (check all that apply)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Jaw joint pain                 | <input type="checkbox"/> Unhappy with appearance of teeth | <input type="checkbox"/> Tooth sensitivity to hot/cold or anything else |
| <input type="checkbox"/> Clenching or grinding of teeth | <input type="checkbox"/> Overbite                         | <input type="checkbox"/> Food gets caught in between teeth              |
| <input type="checkbox"/> Discolored teeth               | <input type="checkbox"/> Underbite                        | If yes, where? _____  |
| <input type="checkbox"/> Crowding/Crooked teeth         | <input type="checkbox"/> Uncomfortable bite               | <input type="checkbox"/> Difficulty chewing                             |
| <input type="checkbox"/> Missing teeth                  | <input type="checkbox"/> Old fillings (gold or silver)    | If yes, where? _____  |
| <input type="checkbox"/> Spaces in between teeth        | <input type="checkbox"/> Old crowns                       | <input type="checkbox"/> Bad breath                                     |
| <input type="checkbox"/> Loose tooth/teeth              | <input type="checkbox"/> Speech problems                  | <input type="checkbox"/> Other _____                                    |
| <input type="checkbox"/> Tooth shape or size            | <input type="checkbox"/> Too much gum tissue when I smile |   |

Have you ever had orthodontic treatment?  Yes  No

If yes, when? \_\_\_\_\_

Have you ever had periodontal (gum tissue) treatment, such as deep cleanings, root planing, or periodontal surgery?  Yes  No

If yes, when? \_\_\_\_\_

Have you whitened your teeth in the past?  Yes  No

If yes, what method? \_\_\_\_\_

Are you interested in learning more about the following? (check all that apply)

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Teeth Whitening       | <input type="checkbox"/> Tooth-colored fillings             | <input type="checkbox"/> At-home oral hygiene care                  |
| <input type="checkbox"/> Orthodontic treatment | <input type="checkbox"/> Dental implants                    | <input type="checkbox"/> Periodontal treatment during pregnancy     |
| <input type="checkbox"/> Veneers               | <input type="checkbox"/> How to prevent periodontal disease | <input type="checkbox"/> Oral hygiene care for infants and toddlers |