Patient Dental History

Patient Name _____ Date _____

Primary reason for this dental appointment:

☐ Routine Examination

☐ Emergency

☐ Consultation

Please circle **YES** or **NO** and describe when appropriate:

Y / N My teeth and gums are healthy. _____
Y / N I usually have dental examinations on a routine basis. Last Visit?_____
Y / N Have your past experiences in a dental office always been positive? _____
Y / N Do you floss on a routine basis? Discuss _____
Y / N Do you want to keep your remaining teeth?_____
Y / N Do you like the appearance of your smile? _____

Y / N Have your wisdom teeth been removed? _____
Y / N Have you ever seen an orthodontist? Who and when? _____
Y / N Have there been any injuries to face, mouth, or teeth? _____

Y / N Have you recently experienced dental pain? Describe _____
Y / N Do you have concerns with the color or appearance of your teeth? _____
Y / N Do you think you have active decay or gum disease? _____
Y / N Do your gums ever bleed? Discuss _____
Y / N Does food catch between your teeth? _____
Y / N Do you have excessive dry mouth?_____
Y / N Do you have any loose teeth? _____
Y / N Do you ever have clicking, popping or discomfort in the jaw joint? _____
Y / N Do you brux or grind? _____
Y / N Do you have a history of Sleep Apnea? _____
Y / N Do you smoke or chew tobacco? _____
Y / N Do you have any sores or growths in your mouth?_____

Name of previous dentist (optional): _____
Date of last full mouth x-rays (16 films or panoramic): _____

Comments/Concerns: _____
_____
_____