Crestview
Dental Group

Dental History Form

Patient Name:_____Date of Birth: _____

Date of Last Dental Visit?_____/_____/_____Reason for the Visit? _____

Date of Last Dental X-rays?_____/_____/_____

Former Dentist:_____Phone: _____

Address:_____City:_____State:_____Zip: _____

Why did you leave your previous dentist? _____

What are your goals in coming to our practice today? _____

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

At-Home Oral Hygiene Care

How often do you brush your teeth? _____

How often do you floss? _____

Do you use mouthwash? Yes/No

If YES, which kind: _____

Do you use any other dental home care products? Yes/No

If YES, which kind: _____

Circle Appropriate Answer (Leave blank if you do not understand the questions)

1. Are you currently experiencing dental pain or discomfort? Yes/No
   If YES, explain: _____
2. Do your gums bleed? Yes/No
   If YES, explain: _____
3. Are your teeth loose? Yes/No
   If YES, explain: _____
4. Do you wear dentures or partials? Yes/No
   If YES, explain: _____
5. Have you ever been told you have gum disease? Yes/No
   If YES, explain: _____

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful dental history and that my dentist and his staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquires set forth above have been answered to my satisfaction.

6. Are your teeth sensitive to hot, cold, sweets or pressure? Yes/No
   If YES, explain: _____

7. Have you ever had any clicking, popping or discomfort in the jaw? Yes/No
   If YES, explain: _____

8. Do you brux or grind your teeth? Yes/No
   If YES, explain: _____

9. Do you wear an occlusal guard? Yes/No

10. Have you ever had orthodontic treatment (braces) before? Yes/No
    If YES, explain: _____

11. Do you have dry mouth? Yes/No
    If YES, explain: _____

12. Does food or floss catch between your teeth? Yes/No
    If YES, explain: _____

13. Have you had any problems or an upsetting dental experience associated with previous dental care? Yes/No
    If YES, explain: _____

14. Are you fearful of dentistry or have anxiety associated with dental treatment? Yes/No
    If YES, explain: _____

15. Have you ever been pre-medicated for dental treatment? Yes/No
    If YES, explain: _____

16. Have you ever had a reaction to anesthetic used with your dental treatment? Yes/No
    If YES, explain: _____

17. Are you happy with your smile? Yes/No
    If NO, please explain: _____

18. What would you change about the present condition of your mouth? _____
    _____

19. Is there anything else you would like us to know about your dental health or dental history? Yes/No
    If YES, explain: _____

_____ _____

Signature of Patient (Parent or Guardian) **Date**

_____ _____

Signature of Dentist **Date**

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