Dental Health History Form

Patient name: _____ _____ _____ _____

First Middle 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: _____ Address: _____ Phone: _____

If you left your previous dentist, what are your reasons? _____

Have you had problems with prior dental treatment? _____

Are you experiencing any pain now? □ Yes □ No

If yes, please explain: _____

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

If yes, why? _____

Have you ever 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? _____

Do you currently have the following concerns with your oral health or smile? (Please check Yes or No)

□ Yes □ No Clenching or grinding teeth
□ Yes □ No Crowding/crooked teeth
□ Yes □ No Discolored teeth
□ Yes □ No Dry mouth/bad breath
□ Yes □ No Missing teeth
□ Yes □ No Loose tooth/teeth
□ Yes □ No Uncomfortable bite
□ Yes □ No Unhappy with appearance of teeth
□ Yes □ No Old fillings (Gold or Silver)
□ Yes □ No Overbite
□ Yes □ No Underbite
□ Yes □ No Speech problems
□ Yes □ No Tooth sensitivity to hot/cold
□ Yes □ No Jaw joint pain (TMJ)
□ Yes □ No Old crowns
□ Yes □ No Too much gum tissue when I smile
□ Yes □ No Spaces between teeth
□ Yes □ No Tooth shape/size
□ Yes □ No Difficulty chewing
If yes, where?_____
□ Yes □ No Food gets caught between teeth
If yes, where?_____

Have you ever had orthodontic treatment? □ Yes □ No

If yes, when?_____

Have you ever had periodontal (gum tissue) treatment? □ Yes □ No

(Such as deep cleanings, root planning, or periodontal surgery?

If yes, when?_____

Have you had your teeth whitened in the past? □ Yes □ No

If yes, what method?_____

Are you interested in any of the following? (please check Yes or No)

□ Yes □ No At-home oral hygiene care
□ Yes □ No Dental implants
□ Yes □ No How to prevent periodontal disease
□ Yes □ No Veneers
□ Yes □ No Orthodontic treatment
□ Yes □ No Periodontal treatment during pregnancy
□ Yes □ No Teeth whitening
□ Yes □ No Tooth-colored fillings
□ Yes □ No Oral hygiene care for infants and toddlers

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or my patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____

Signature of patient, parent, or guardian Date

(Please type your name in the space provided above to electronically sign your name)