Dental Health History Form

Today's Date _____

Patient Name: First _____ MI ___ Last _____ Nickname _____

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

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 _____

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? _____

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

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

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)*

☐ Teeth Whitening
☐ Orthodontic treatment
☐ Veneers
☐ Tooth-colored fillings
☐ Dental implants
☐ How to prevent periodontal disease
☐ At-home oral hygiene care
☐ Periodontal treatment during pregnancy
☐ Oral hygiene care for infants and toddlers