
PATIENT'S NAME _____
Last First Initial Date of Birth

Purpose of initial visit _____
Are you aware of a problem? _____
How long since your last dental visit? _____
What was done at that time? _____
Previous dentist's name _____
Address _____ Phone _____
What was the last time your teeth were cleaned? _____

CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER, PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

Have you made regular visits? ..... YES NO
How often: _____
Were dental xrays taken? ..... YES NO
Have you lost any teeth or have any teeth been removed? ..... YES NO
Why? _____
Have they been replaced? ..... YES NO
How have they been replaced?
Fixed bridge _____ Age _____
Removable bridge _____ Age _____
Denture _____ Age _____
Are you unhappy with the replacement? ..... YES NO
If yes, explain: _____
_____
Do you clench or grind your teeth? ..... YES NO
Does your jaw click or pop? ..... YES NO
Have you experienced any pain or soreness in the muscles on your face or around your ear? ..... YES NO
Do you have frequent headaches, neck aches or shoulder aches? ..... YES NO
Does food get caught in your teeth? ..... YES NO
Are any of your teeth sensitive to Hot Cold Sweets Pressure
Do your gums bleed or hurt? ..... YES NO
When? _____
How often do you brush your teeth? _____ When? _____
Do you use dental floss? ..... YES NO
How often? _____
Are any of your teeth loose, tipped, shifted or chipped? ..... YES NO
Are you unhappy with the appearance of your teeth? ..... YES NO
How do you feel about your teeth in general? _____
Do you feel your breath is offensive at times? ..... YES NO
Have you ever had gum treatment or surgery? ..... YES NO
What? _____
Where? _____
When? _____
Have you had any orthodontic work? ..... YES NO
Have you had any unpleasant dental experiences or is there
anything about dentistry that you strongly dislike? ..... YES NO
Do you have any concerns? ..... YES NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____