

Personal Dental History

Patient Name: _____ Date: _____

Reason for today's visit: _____

Have you had or do you currently have any of the following?

- | | | | |
|--|---|--|--------------------------------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> NO | Orthodontic Treatment (Braces/Retainer) | <input type="checkbox"/> Yes <input type="checkbox"/> NO | Taken antibiotic before dental appts |
| <input type="checkbox"/> Yes <input type="checkbox"/> NO | Oral Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> NO | Clicking/Popping of Jaw |
| <input type="checkbox"/> Yes <input type="checkbox"/> NO | 3 rd molars removed (Wisdom Teeth) | <input type="checkbox"/> Yes <input type="checkbox"/> NO | Bleeding/ Swollen Gums |
| <input type="checkbox"/> Yes <input type="checkbox"/> NO | Deep cleaning | <input type="checkbox"/> Yes <input type="checkbox"/> NO | Jaw Pain |
| <input type="checkbox"/> Yes <input type="checkbox"/> NO | Gum Treatment | <input type="checkbox"/> Yes <input type="checkbox"/> NO | Floss |
| <input type="checkbox"/> Yes <input type="checkbox"/> NO | Root Canal Therapy | <input type="checkbox"/> Yes <input type="checkbox"/> NO | Mouth Rinse |
| <input type="checkbox"/> Yes <input type="checkbox"/> NO | Dentures | <input type="checkbox"/> Yes <input type="checkbox"/> NO | Clench/Grind |
| <input type="checkbox"/> Yes <input type="checkbox"/> NO | Partials | <input type="checkbox"/> Yes <input type="checkbox"/> NO | Canker Sores |
| <input type="checkbox"/> Yes <input type="checkbox"/> NO | Oral Piercing | <input type="checkbox"/> Yes <input type="checkbox"/> NO | Cold Sores |
| <input type="checkbox"/> Yes <input type="checkbox"/> NO | Teeth Whitening | <input type="checkbox"/> Yes <input type="checkbox"/> NO | Dental Implants |
| <input type="checkbox"/> Yes <input type="checkbox"/> NO | Night Guard | <input type="checkbox"/> Yes <input type="checkbox"/> NO | Loose Teeth |
| <input type="checkbox"/> Yes <input type="checkbox"/> NO | Manual Toothbrush | <input type="checkbox"/> Yes <input type="checkbox"/> NO | Sensitivity to Hot |
| <input type="checkbox"/> Yes <input type="checkbox"/> NO | Power Toothbrush | <input type="checkbox"/> Yes <input type="checkbox"/> NO | Sensitivity to Cold |
| <input type="checkbox"/> Yes <input type="checkbox"/> NO | Water Pik | <input type="checkbox"/> Yes <input type="checkbox"/> NO | Latex Allergy |
| <input type="checkbox"/> Yes <input type="checkbox"/> NO | Veneers | <input type="checkbox"/> Yes <input type="checkbox"/> NO | Broken/ Dislocated Jaw |
| <input type="checkbox"/> Yes <input type="checkbox"/> NO | Bad Breath | <input type="checkbox"/> Yes <input type="checkbox"/> NO | Missing teeth |

Name of previous Dentist: _____ Date of last visit: _____

Are you happy with the appearance of your teeth? Yes NO If no, what would you like to change? _____

Have you ever had a bad experience /problem associated with dental treatment? Yes NO If yes, please explain.

Please read the paragraph below and sign. Your signature will indicate that you have read the paragraph and agree to these statements.

The information given here regarding the patient medical and dental histories is accurate and complete to the best of my knowledge. I will not hold the dentist or her staff responsible for any errors or omissions that I may have made in the completion of this form. I understand that if any changes occur, it is my responsibility to inform the dentist and her staff.

Patient/Guardian Signature: _____ Date: _____

For Office Use Below

I verbally reviewed the medical/dental information above with the patient/guardian.

Initials: _____ Date: _____ Initials: _____ Date: _____