Dental History Form

Patient Name: _____ Date of Birth: _____

Date of Last Dental Visit? _____/_____/_____ Reason for THAT Visit? _____

If you left your previous dentist, what was the reason? _____

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: _____

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. Have you ever had orthodontic treatment (braces) before? Yes/No

If YES, explain: _____

4. Have you had any upsetting dental experience associated with previous dental care? Yes/No

If YES, explain: _____

5. Are you fearful of dentistry or have anxiety associated with dental treatment? Yes/No

If YES, explain: _____

6. Have you ever been pre-medicated for dental treatment? Yes/No

If YES, explain: _____

7. Have you ever had a reaction to anesthetic used with your dental treatment? Yes/No

If YES, explain: _____

8. Are you happy with your smile? Yes/No

If NO, please explain: _____

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

_____

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/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction.

_____ _____

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