

Dental History

*Required Fields

Dental History

Patient First Name:*

Patient Middle Initial:

Patient Last Name:*

Patient Birth Date:*



Reason for your scheduled appointment? You can choose more than one.

Just a regular exam

Cleaning

Cosmetic Consult

Pain

Second Opinion

Other

Previous Dentist:

Why are you changing your dentist?

When was your last dental exam?



When did you have your last dental cleaning?



Personal History

How often do you brush?

- Every time I eat
- Twice a day
- Occasionally
- Never

- Three times a day
- Once a day
- Sometimes

How often do you floss?

- Every time I eat
- Twice a day
- Occasionally
- Never

- Three times a day
- Once a day
- Sometimes

Does going to the dentist make you nervous?

- No
- Yes, moderately

- Yes, slightly
- Yes, extremely

Have you ever had a bad experience at the dentist?

- Yes
- No

Please add any details here

Have you ever had complications from past dental treatment?

- Yes
- No

Please add any details here

Have you ever had trouble getting numb or had any reactions to a local anaesthetic?

- Yes
- No

Please add any details here

Periodontal / Gum disease

Do your gums bleed sometimes, or are they ever painful when brushing or flossing?

- Yes
- No

Please add any details here

Have you ever been treated for gum disease or been told you have lost bone around your teeth?

- Yes
- No

Please add any details here

Is there anyone with a history of gum / periodontal disease in your family?

- Yes
- No

Please add any details here

Have you ever experienced or been told by a previous dentist that you have gum recession, or can you see more of the roots of your teeth?

- Yes
- No

Please add any details here

Have you ever had any teeth become loose without an external injury, or do you have difficulty biting into harder fruits and vegetables?

- Yes

No

Please add any details here

Dental Problems

Are your teeth sensitive to hot, cold, or sweet foods or liquids? Do you avoid brushing a part of your mouth because of sensitive teeth?

Yes

No

Please add any details here

Do you feel that your mouth is too dry or have difficulty swallowing food?

Yes

No

Please add any details here

Do you frequently get food caught between any teeth?

Yes

No

Please add any details here

Are you aware of sores or irritated areas in the mouth?

Yes

No

Please add any details here

Do you grind your teeth? Have you been told by a partner or a previous dentist that you grind your teeth?

- Yes
- No

Please add any details here

Improvements

Is there something you would like to change about your smile?

- | | |
|-------------------------------------------------------|------------------------------------------------------------------------|
| <input type="checkbox"/> The colour of my teeth | <input type="checkbox"/> Close spaces or restore worn-out/broken teeth |
| <input type="checkbox"/> Change the shape of my teeth | <input type="checkbox"/> Make my teeth straighter |
| <input type="checkbox"/> Replace missing teeth | <input type="checkbox"/> Nothing, I like my smile |
| <input type="checkbox"/> Other | |

I would be interested in learning more about the following topics

- | | |
|-------------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Teeth whitening | <input type="checkbox"/> Cosmetic evaluation |
| <input type="checkbox"/> Replacement of missing teeth | <input type="checkbox"/> Straight teeth |
| <input type="checkbox"/> Sedation | <input type="checkbox"/> White fillings |
| <input type="checkbox"/> Home care | <input type="checkbox"/> Breath control |
| <input type="checkbox"/> Other | |

Signature: *

Sign

Submit