Time 9:46 AM

Elmore Family Dentistry

Date 6/24/2019

Dental History Form

Patient Name:

Birth Date:

Date Created:

Dental History

Purpose of initial visit?		Comment	
Are you aware of a problem?		Comment	
How long since your last dental visit?		Comment	
What was done at that time?		Comment	
Previous Dentist's name and address and phone number?		Comment	
When was the las time your teeth were cleaned?		Comment	

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

Have you made regular visits? How often?	◯ Yes ◯ No	If yes	
Were dental x-rays taken?	◯ Yes ◯ No	If yes	
Have you lost any teeth or have any teeth been removed?	◯ Yes ◯ No	If yes	
Why did you loose teeth?	◯ Yes ◯ No	If yes	
Have lost teeth been replaced?	◯ Yes ◯ No	If yes	

How have lost teeth been replaced?

Fixed Bridge	◯ Yes ◯ No	Removable bridge	◯ Yes ◯ No	Denture	◯ Yes ◯ No	Implant	◯ Yes ◯ No

Are you unhappy with the replacement? Please explain why.	◯ Yes ◯ No	If yes	
Would you like to know about permanent replacements?	◯ Yes ◯ No	If yes	
Have you ever had any problems or complications with previous dental treatment? Please explain.	◯ Yes ◯ No	If yes	
Do you clench or grind your teeth?	◯ Yes ◯ No		
Does you jaw click or pop?	◯ Yes ◯ No		
Have you experienced any pain or soreness in the muscles or your face or around your ear?	◯ Yes ◯ No		
Do you have frequent headaches, neckaches or shoulder aches?	◯ Yes ◯ No		
Does food get caught in your teeth?	◯ Yes ◯ No		
Do your gums bleed or hurt? If so, when?		Comment	

Are your teeth sensitive to?

Hot?	◯ Yes ◯ No	Cold?	◯ Yes ◯ No	Sweets?	◯ Yes ◯ No	Pressure?	◯ Yes ◯ No

Do you experience dry mouth?	◯ Yes ◯ No		
How often do you brush your teeth and when?		Comment	
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?		Comment	
Do you feel your breath is offensive at time?	◯ Yes ◯ No		
Have you ever had gum treatment or surgery?	◯ Yes ◯ No		
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	If yes	
Do you have any questions or concerns?	◯ Yes ◯ No	If yes	

Comments

Signature of patient

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

Signature of Patient, Parent or Guardian:

X Date:_____

Signature of Dentist

Dentist Signature

Signature of Dentist:

X Date:_____