

# Dental History Form

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Date of Last Dental Visit? \_\_\_\_/\_\_\_\_/\_\_\_\_ Reason for the Visit? \_\_\_\_\_

Date of Last Dental X-rays? \_\_\_\_/\_\_\_\_/\_\_\_\_

Former Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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

What are your goals in coming to our practice today? \_\_\_\_\_

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: \_\_\_\_\_

Do you use any other dental home care products? 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. Are your teeth loose? Yes/No  
If YES, explain: \_\_\_\_\_
4. Do you wear dentures or partials? Yes/No  
If YES, explain: \_\_\_\_\_
5. Have you ever been told you have gum disease? Yes/No  
If YES, explain: \_\_\_\_\_

6. Are your teeth sensitive to hot, cold, sweets or pressure? Yes/No  
If YES, explain: \_\_\_\_\_
7. Have you ever had any clicking, popping or discomfort in the jaw? Yes/No  
If YES, explain: \_\_\_\_\_
8. Do you brux or grind your teeth? Yes/No  
If YES, explain: \_\_\_\_\_
9. Do you wear an occlusal guard? Yes/No
10. Have you ever had orthodontic treatment (braces) before? Yes/No  
If YES, explain: \_\_\_\_\_
11. Do you have dry mouth? Yes/No  
If YES, explain: \_\_\_\_\_
12. Does food or floss catch between your teeth? Yes/No  
If YES, explain: \_\_\_\_\_
13. Have you had any problems or an upsetting dental experience associated with previous dental care?  
Yes/No  
If YES, explain: \_\_\_\_\_
14. Are you fearful of dentistry or have anxiety associated with dental treatment? Yes/No  
If YES, explain: \_\_\_\_\_
15. Have you ever been pre-medicated for dental treatment? Yes/No  
If YES, explain: \_\_\_\_\_
16. Have you ever had a reaction to anesthetic used with your dental treatment? Yes/No  
If YES, explain: \_\_\_\_\_
17. Are you happy with your smile? Yes/No  
If NO, please explain: \_\_\_\_\_
18. What would you change about the present condition of your mouth? \_\_\_\_\_  
\_\_\_\_\_
19. Is there anything else you would like us to know about your dental health or dental history? Yes/No  
If YES, explain: \_\_\_\_\_

**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**

---

**Signature of Dentist**

---

**Date**