Welcome to THE DENTAL PEOPLE!

PATIENT DENTAL HISTORY

PATIENT NAME: ______________________________ **DATE:** ______________

1. What is the reason for your visit today? ______________________________

2. Date of last dental visit and what was done? ______________________________

3. Do you have any dental problems now? YES NO
If yes, please describe: ______________________________

4. Do you have Dental anxiety or Fear of the dentist? YES NO
If yes, describe: ______________________________

5. Are you satisfied with you teeth's appearance? YES NO

6. What would you like to change about your smile? ______________________________

7. How often do you brush? (circle one) Not at all Once a day Twice a day 3 times a day More than 3

8. Do you floss? YES NO If yes, how often? ______________________________

9. Is there anything else about having dental treatment that you would like us to know? YES NO
If yes, describe: ______________________________

10. Are there any other dental circumstances in the past that concern you? YES NO
If yes, describe: ______________________________

Circle Yes or No

1) **Do your gums bleed while brushing or flossing? YES NO**
2) **Are your teeth sensitive to hot foods or drinks ? YES NO**
3) **Are your teeth sensitive to cold foods, drinks or air? YES NO**
4) **Are your teeth sensitive to sweet or sour? YES NO**
5) **Do you feel pain to any of your teeth? YES NO**
   Where and how long? ______________________________
6) **Do you have any sores or lumps in or near your mouth? YES NO**
7) **Have you had any head, neck, or jaw injuries? YES NO**
8) **Have you had any orthodontic work? YES NO If yes, braces or invisalign (CIRCLE)**
9) **Have you ever had any difficult extractions in the past? YES NO**
10) **Have you ever had prolonged bleeding following extractions? YES NO**
11) **Have you ever had instruction on the correct method of brushing your teeth? YES NO**
12) **Have you ever had instructions on the care of your gums? YES NO**
13) **Do you GAG easily? YES NO**
14) **Have you ever experienced any of the following problems in you jaw?**
    a. **Clicking YES NO**
    b. **Joint pain YES NO**
    c. **Ear pain YES NO**
    d. **Neck pain YES NO**
    e. **Difficulty opening or closing jaw YES NO**
    f. **Difficulty chewing YES NO**
    g. **Do you have frequent headaches? YES NO**
    h. **Do you clench or grind your teeth? YES NO**