Patient Name ____
last first m.i.

1. Chief complaint or reason for visit ____
____

2. Do you feel nervous about having dental treatment? YES ☐ NO ☐
If Yes: ☐ Somewhat ☐ Moderately ☐ Extremely

3. Have you ever had a bad experience in a dental office? YES ☐ NO ☐
____

4. Date of last: Dental Visit ____________________ Dental X-Rays ____________________
Previous cleaning interval: ☐ 3 mos. ☐ 4 mos. ☐ 6 mos.

5. Are you having pain or discomfort at this time? YES ☐ NO ☐
____

6. Do you have or have you had any of the following? (Please circle)
Teeth sensitive to: ☐ HOT / ☐ COLD / ☐ SWEETS / ☐ BITING / ☐ CHEWING
☐ Bleeding or swollen gums
☐ Bad taste or mouth odor
☐ Loose or separating teeth
☐ Partial or complete dentures
☐ Gum surgery
☐ Implants
☐ Popping or clicking of jaw joints
☐ Facial or jaw pain
☐ Frequent headaches
☐ Difficulty swallowing or chewing
☐ Braces (Orthodontia)
☐ Sleep apnea

7. How often do you brush? ____________________ Floss? ____________________

8. What texture brush do you use? ☐ SOFT ☐ MEDIUM ☐ HARD

9. List any other cleaning devices you use regularly (i.e. rinses, toothpicks, irrigation sprays, etc.)
____

10. Do you gag easily? YES ☐ NO ☐

11. Do you smoke? How much? ______________________________ YES ☐ NO ☐

12. Do you use chewing tobacco? What type and how much? ____________________ YES ☐ NO ☐

13. Is it important to you to keep your teeth? YES ☐ NO ☐

14. Are you satisfied with the appearance of your teeth? YES ☐ NO ☐

15. Reason for leaving last dentist: ____

16. Please add anything else that you feel is important: ______________________________
____

______________________________ ____________________
Patient Signature Date

DENTAL HISTORY