DENTAL HISTORY

Do you have a specific dental problem? Yes___ No___
If yes please
explain_____
_____
____

Do you have dental examinations on a regular basis? Yes___ No___
Date of last Visit:
_____

Would you describe your current dental Health as good? Yes___ No ___

Do you think you have decay or active gum disease? Yes___ No ___
If yes please explain:
_____
____

Do your gums ever bleed? Yes ___ No ___

Do you brush on a routine basis? Yes ___ No ___

Do you floss on a routine basis? Yes ___ No ___

Are you nervous about having dental treatment? Yes ___ No ___
If yes please explain:
_____
_____
____

Have you had a bad experience at a dental office in the past? Yes ___ No ___
If yes please explain:
_____
_____
____

Do you want to keep your remaining teeth: Yes ___ No ___

Do you like your smile? Yes ___ No ___
Why:
_____

Name of previous dentist? (Optional) _____

Name of your medical doctor: _____

Who referred you to our office? _____

Do you wish to speak with the doctor privately about any problem? Yes ___ No ___

I have read my dental history and confirm that it adequately states past and present conditions.

_____

_____

Patient Signature (Parent or Guardian) Date