

| PA | TIENT'S NAMEL | ast | First | | Init | ial | Date of Birth |
|---|---|---------------------------------------|----------------------|---------|------|------|---------------|
| 1. | Purpose of initial visit | | | | | | COMMENTS |
| | Are you aware of a problem? | | | | | | |
| 2. | Are you aware of a problem? | | | | | | |
| 3. | How long since your last denta | I visit? | | | | | |
| 4. | What was done at that time? _ | | | | | | |
| 5. | Previous dentist's name | | | | _ | | |
| | Previous dentist's name | | Tel. () | | | | |
| 6. | When was the last time your te | eth were cleaned? | | | _ | | |
| CIR | CLE THE APPROPRIATE ANS | | | | | | |
| 7. | Have you made regular visits? How often? | | | YES | NO | | |
| 8. | Were dental x-rays taken? | | | YES | NO | | |
| 9. | Have you lost any teeth or have | e any teeth been remov | red? | YES | NO | | |
| 10. | Why? Have they been replaced? | | | YES | NO | | |
| | How have they been replaces? | | | | | | |
| | a. Fixed bridge b. Removable bridge | | Age | | | | |
| | c. Denture | | Age | | _ | | |
| 12. | c. Denture Are you happy with the replace | | | | NO | | |
| | If no, explain | | | | | | |
| 13. | Would you like to know about p | ermanent replacement | 5? | YES | NO | | |
| 14. | Have you ever had any problem | | | nt? YES | NO | | |
| | If yes, explain | | | | _ | | |
| 15. | Do you clench or grind your tee | th? | | YES | NO | | |
| 16. | Does your jaw click or pop? | · · · · · · · · · · · · · · · · · · · | | YES | NO | | |
| 17. | Have you experienced any pair around your ear? | | | YES | NO | | |
| | Do you have frequent headache | es, neckaches or shoul | der aches? | YES | NO | | |
| 19. | Does food get caught between Are any of your teeth sensitive | your teeth? | nuncto n | YES | NO | | |
| 21. | Do your gums bleed or hurt? | to not cold | sweetsp | YES | NO | | |
| | | | | | | | |
| 22. | When? How often do you brush your tee Do you use dental floss? | eth? | When? | VES | NO | | |
| | | | | | | | |
| 24. | Are any of your teeth loose, tipp | oed or shifted? | av baya any dia daya | YES | NO | | |
| 25. | Are you happy with the appeara teeth that bother you? | | | YES | NO | | |
| 26. | How do you feel about your tee | | | | | | |
| 27. | Do you feel your breath is offen | eive at times? | | VES | NO | | |
| | Have you ever had gum treatme | | | | | | |
| | What | | | | | | |
| | Where | | | | _ | | |
| 29. | Have you had any orthodontic v | vork? | | YES | NO | | |
| 30. | Have you had any unpleasant d | lental experiences or is | there anything about | | | | |
| | dentistry that you strongly dislike | | | | | | |
| 31. | Do you have any questions or o | oncerns? | | YES | NO | | |
| | | | | | | | |
| I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE | | | | | | | |
| PATIENT'SSIGNATURE | | | | | | DATE | |
| | TIST'S SIGNATURE | | | | | DATE | |
| _ | | | | | | | |
| 100 | ANEST. | | | | | | MED, ALERT |

AITEST

Form No. 150DH

DENTAL HISTORY

MED. ALERT