Dental Health History Form

09/15/2022

Last Name: _____ First Name: _____ Birthdate: _____

What are your goals in coming to our practice today? _____

What is important to you in a dentist or dental practice? _____

What has been your experience with the dentist in the past? _____

Did you have radiographs taken at your last dental visit? Y ☐ N ☐ Date: _____

Date of your last hygiene recare appointment (cleaning or perio maintanance): _____

Name of former dentist and location: _____ Phone: _____

Have you had problems with prior dental treatment? _____

Are you experiencing any pain now? Y ☐ N ☐

If yes, please describe _____

Have you ever been pre-medicated for dental treatment? Y ☐ N ☐

If yes, why? _____

Are you interested in sedation dentistry? Y ☐ N ☐

What concerns do you currently have with your oral health or smile? (Check all that apply)

- ☐ Jaw joint pain
- ☐ Bleeding gums
- ☐ Crowding or crooked teeth
- ☐ Clenching or grinding teeth
- ☐ Missing teeth
- ☐ Spaces in between teeth
- ☐ Loose tooth/teeth
- ☐ Tooth shape or size
- ☐ Difficultly chewing
- ☐ Other _____
- ☐ Unhappy with appearance of teeth
- ☐ Overbite
- ☐ Underbite
- ☐ Uncomfortable bite
- ☐ Old fillings (gold or silver)
- ☐ Old discolored crowns
- ☐ Too much gum tissue when I smile
- ☐ Tooth sensitivity to hot/cold or anything else
- ☐ Bad breath

Have you ever had orthodontic treatment? Y ☐ N ☐

If yes, when? _____

Have you ever have periodontal/gum treatment, such as deep cleanings, root planning or periodontal surgery?

Y ☐ N ☐

If yes, when? _____

Have you whitened your teeth in the past? Y ☐ N ☐

If yes, when? _____

Are you interested in learning more about the following? (check all that apply)

- ☐ Teeth Whitening
- ☐ Orthodontic treatment
- ☐ Veneers
- ☐ Tooth- colored fillings
- ☐ Dental implants
- ☐ Prevention of periodontal disease
- ☐ At home oral hygiene care
- ☐ Periodontal treatment during pregnancy
- ☐ Oral hygiene for infants and toddlers