Dental History

Patient Name _____

Primary reason for this appointment □ Examination □ Emergency □ Consultation

1) Do you have a specific dental problem?

   Describe _____

2) Do you think you have active decay? _____

3) Do you think you have gum disease? _____

4) Do your gums ever bleed? _____

5) Does food catch between your teeth? _____

6) Any loose teeth? _____

7) Do you daily drink liquids that have sugar in them (e.g., sodas, coffee, tea, etc.)?____

8) Do you have dental examinations on a regular basis? Last visit? _____

9) Name of previous dentist? _____

10) Have your past experiences in a dental office always been positive? _____

11) Do you like your smile? _____ If not, why? _____

12) Is there a history of Diabetes in your family?_____ If yes, who?_____

13) Is there anyone in your family with a partial or denture?_____ If yes, who?_____

14) Have your or any relative had orthodontic treatment? _____If yes, who?_____

15) Do you grind and/or have any jaw pain? _____

16) Do you smoke or chew? If yes, how much per day? _____

17) How often do you brush? _____Floss? _____

18) Do you want to keep your remaining teeth? _____