DENTAL Health History Form

Patient Name: _____ **Date:**_____

What is your main concern for coming to our office today?_____

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

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

Approximate Date of your last X-rays:_____

Approximate Date of your last dental cleaning:_____

Former dentist and/or city:_____

Reasons for leaving your previous dentist:_____

Have you had problems with prior dental treatment?_____

Are you experiencing any pain now? Please describe:_____

Have you ever had to take antibiotics before dental treatment (premed)?_____

Have you ever had issues/concerns with getting numb in your mouth?_____

Anxiety level (check one): ☐very nervous ☐slightly nervous ☐not really nervous at all

Would you share why you might be nervous?_____

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

☐jaw joint pain
☐clenching or grinding
☐discolored teeth
☐crowded/crooked teeth
☐unhappy with appearance of teeth
☐ bad breath
☐old fillings
☐spaces/gaps in teeth
☐ hot/cold sensitivity
☐food gets caught in between teeth
☐old crowns
☐other:_____

Have you ever had orthodontic treatment (braces)?_____

Have you had your wisdom teeth molars removed?_____

Have you ever had periodontal (gum) treatment such as deep cleanings, scaling, periodontal surgery?_____

Have you whitened your teeth in the past?_____What method?_____

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

☐teeth whitening
☐orthodontic treatment
☐veneers
☐tooth-colored fillings
☐dental implants
☐how to prevent periodontal (gum) disease

--Thank You--