DENTAL HISTORY

1. Purpose of your initial visit _____
   _____
2. How long since your last dental visit? _____
3. What was done at that visit? _____
   _____
4. Previous dentist's name? _____

CIRCLE THE APPROPRIATE ANSWER

COMMENTS

5. Have you made regular dental visits?.....Yes No
   How often _____
6. Date of you last dental X-rays ? _____
7. Have you lost any teeth ? .....Yes No
8. Have they been replaced? ..... Yes No
9. How have they been replaced?
   a. Fixed Bridge Age_____
   b. Removable Partial Denture Age_____
   c. Denture Age_____
10. Are you happy with your replacement teeth? .....Yes No
    If no, explain _____
    _____
11. Have you had any periodontal or gum treatments in the past.....Yes No
12. Do your gums bleed or hurt?.....Yes No
    When? _____
13. Do you clinch or grind your teeth? .....Yes No
14. Does your jaw click or pop when you open ? .....Yes No
15. Have you had any pain in muscles of your face
    or around your ear? .....Yes No
16. Do you have frequent headaches, neckaches, or shoulder pain? Yes No
17. Have your wisdom teeth been removed?.....Yes No
18. Have you ever worn braces?.....Yes No

19. Are you happy with the appearance of your teeth? .....Yes No
20. Have you had any unpleasant experiences or anything about
    dentistry that you strongly dislike? _____
    _____

21. Do you have any questions or concerns? _____
    _____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

Patient Signature _____Date_____

Dentist's Signature _____Date_____