

Dental Implant Centers

Patient Name: _____ DENTAL HISTORY FORM

Please answer ALL questions. All information is completely confidential

What is the reason for your visit today? _____

Date of last dental visit: _____ Date of last dental cleaning: _____ Date of last full mouth x-ray: _____

What was done at your last dental visit? _____

Name & phone # of your previous dentist: _____

How often do you have dental exams? _____ Brush your teeth? _____ Floss your teeth? _____

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Please circle either yes or no for the following questions:

Do you have any dental problems, pain or sensitivity right now? -----Yes No

If yes, please describe: _____

Do you feel nervous about having dental treatment? -----Yes No

If yes, what is your biggest concern? _____

Have you ever had:

Orthodontic treatment? -----Yes No

Oral surgery? -----Yes No

Periodontal (gum) treatment? -----Yes No

Clicking or popping of the jaw? -----Yes No

Joint pain? -----Yes No

Difficulty opening or closing your mouth? -----Yes No

Mouth odor or a bad taste? -----Yes No

Dry mouth? -----Yes No

Food caught in your teeth? -----Yes No

An upsetting dental experience? -----Yes No

Do you:

Clench or grind your teeth while awake or asleep? -----Yes No

Breathe through your mouth? -----Yes No

Have a tired jaw, especially in the mornings? -----Yes No

Chew tobacco? -----Yes No

Smoke cigarettes or cigars? -----Yes No

If you smoke cigarettes or cigars, how many per day do you smoke? _____

Would you like to improve the appearance of your teeth? -----Yes No

Would you like to have whiter teeth? -----Yes No

Is there anything else about dental treatment that you would like use to know? -----Yes No

If so, please describe here: _____

PATIENT'S SIGNATURE (OR GUARDIAN/PARENT IF PATIENT IS A MINOR)

DATE