

Dental History

Name: _____

Type of Dental Treatment Desired (Check one)

- Emergency (Relief of pain and treatment of chief complaint only)
- Complete (Initial examination and treatment as required)
- Consultation (Please specify) _____
- Other _____

Date of last dental treatment: _____

Dental services received: _____

Describe chief dental concern: _____

	Please check:	YES	NO
Do you feel discomfort in your teeth when chewing?	—	—	—
Do you have any places where food packs between teeth?	—	—	—
Do you feel discomfort in your jaw or ears when chewing?	—	—	—
Do you have pain, discomfort, sores, or lumps anywhere in your head or neck area?	—	—	—
Do you suffer frequent headaches?	—	—	—
Do you clench or grind your teeth?	—	—	—
Do your gums bleed when chewing or brushing?	—	—	—
Have you ever been treated for gum disease?	—	—	—
Do you have unpleasant breath or an unpleasant taste in your mouth?	—	—	—
Are you confident in your ability to properly clean your teeth?	—	—	—
Do you feel you chew efficiently?	—	—	—
Are you pleased with the appearance of your teeth?	—	—	—
Have you noticed any darkening of your teeth?	—	—	—
Have you lost any teeth?	—	—	—
If so, were they replaced?	—	—	—
Do you feel you will eventually lose all of your teeth even with proper care?	—	—	—
Do any members of your family, including your parents, wear dentures or partials?	—	—	—
Are you concerned about the finances required to return your mouth to excellent dental health?	—	—	—
Do you get frustrated because you always have something to be treated or repaired when you visit the dentist?	—	—	—

If, by magic, you could change anything about your teeth, what would you change?
