Health Record / Adult

Patient Name	File #

The following confidential information is important for the dentist to know in planning your dental care.
Please answer each question as completely as you can. Thank you.

Dental History

Reason for this visit:

Previous dentist (name and location)

When was your last dental visit?	What was done then?
How often did you visit the dentist before then?	Have you had a complete series of dental films (x-rays) taken? ☐ Yes ☐ No When? Where?
What types of dental treatment have you had in the past?	
How often do you brush your teeth?	How often do you floss your teeth?
Is there anything about your teeth that you would change if you could?	Do you snack between meals? ☐ Yes ☐ No What types of food?

Do any of the following apply to you?

Please ✓

☐ Yes ☐ No Tooth sensitivity:
☐ Hot ☐ Cold ☐ Sweets ☐ Chewing/pressure ..... _____

☐ Yes ☐ No Toothache ..... _____

☐ Yes ☐ No Teeth removed ..... _____

☐ Yes ☐ No Unpleasant dental experience ..... _____

☐ Yes ☐ No Gums bleed or sore ..... _____

☐ Yes ☐ No Loose teeth ..... _____

☐ Yes ☐ No Mouth odor or bad taste ..... _____

☐ Yes ☐ No Food trap area ..... _____

☐ Yes ☐ No Swelling, lumps or sores in mouth ..... _____

☐ Yes ☐ No Grind or clench teeth ..... _____

☐ Yes ☐ No Jaw joint pain or noise ..... _____

☐ Yes ☐ No Jaw locks ..... _____

☐ Yes ☐ No Bite is off/crowded teeth ..... _____

☐ Yes ☐ No Orthodontic treatment. When? ..... _____

☐ Yes ☐ No Other: _____

_____

☐ Yes ☐ No Are you happy with the appearance of your teeth? ..... _____

(Over Please)