The Dentist on Jones Road

Dental History

Patient's Name _____
Last First Date of Birth

Purpose of initial visit_____

1. Are you aware of a problem?_____
2. How long since your last dental visit? _____
3. Previous dentist name. _____#_____
4. When was the last time your teeth were cleaned? _____

PLEASE CIRCLE THE APPROPRIATE ANSWER

7. Have you made regular dental visits? ……..Yes No
8. Were dental x-rays taken? ……Yes No
9. Have you lost any teeth or have any teeth been removed? ……Yes No
10. Have you had any problems or complications with previous Dental treatment? If so please explain: _____
    _____
11. Do you clinch or grind your teeth? ……Yes No
12. Does your jaw click or pop?……Yes No
13. Do you have frequent headaches, neckaches or shoulder aches?Yes No
14. Does food get caught in your teeth? ……Yes No
15. Are any of your teeth sensitive to? Hot Cold Sweets Pressure
16. Do you your gums bleed or hurt? ……..Yes No
    When? _____
17. Do you use dental floss? ……Yes No
    How often? _____
18. Are any of your teeth loose, tipped, shifted or chipped? ……Yes No
19. Is there anything you would like to change about the
20. appearance of your teeth? ……..Yes No
21. Do you feel your breath is offensive at times? ……Yes No
22. Have you ever had gum treatment or surgery? ……Yes No
23. Have you had orthodontic work? ……Yes No
24. Have you had any unpleasant dental experiences or is there anything About dentistry that you strongly dislike? _____
    _____
25. Do you have any questions or concerns? ……Yes No

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE._____
Patient Name Date