PARADISE
DENTAL PROFESSIONALS

DENTAL HISTORY

Patient Name _____ Patient Number (office use only _____
Last First MI

1. Purpose of initial visit _____
2. Are you aware of a problem? _____
3. How long since your last dental visit? _____
4. What was done at that time? _____
   _____
5. Previous dentist's name: _____
   Address: _____ Phone _____
6. When was the last time your teeth were cleaned? _____
   CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER, PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.
7. Have you made regular visits? ..... YES NO
   How often? _____
8. Were dental x-rays taken? ..... YES NO
9. Have you lost any teeth or had any teeth removed? ..... YES NO
   Why? _____
10. Have they been replaced? ..... YES NO
11. How have they been replaced?
    a. Fixed bridge _____ Age _____
    b. Removable bridge _____ Age _____
    c. Denture _____ Age _____
    d. Implant _____ Age _____
12. Are you unhappy with the replacement? ..... YES NO
    If yes, please explain: _____
13. Would you like to know more about permanent replacements? ..... YES NO
14. Have you ever had problems or complications with a previous dental treatment? ..... YES NO
    If yes, please explain: _____
15. Do you clench or grind your teeth? ..... YES NO
16. Does your jaw pop or click? ..... YES NO
17. Have you experienced any pain or soreness in the muscles or your face? ..... YES NO
18. Do you have frequent headaches, neck aches, shoulder aches? ..... YES NO
19. Does food get caught in your teeth? ..... YES NO
20. Are your teeth sensitive to: ___ Hot ____ Cold ___ Sweet ___ Pressure
21. Do your gums bleed or hurt? ..... YES NO

22. Do you experience dry mouth? …… YES NO
23. How often do you brush your teeth? _____ When? _____
24. How often do you floss your teeth? _____ When? _____
25. Are any of your teeth loose, tipped, shifted or chipped? …….. YES NO
26. Are you unhappy with the appearance of your teeth? …… YES NO
27. How do you feel about your teeth in general? _____
28. Do you feel you have bad breath? …….. YES NO
29. Have you ever had gum treatment or surgery? …… YES NO
    What? _____
    When? _____
    Where? _____
30. Have you had any orthodontic work? _____
31. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike? _____
32. Do you have any questions or concerns? …….. YES NO

I CERTIFY THAT THE ABOVE INFORMATION THAT IS COMPLETE AND ACCURATE

PATIENT'S/GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

Notes: (for office use)

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