Patient's Name ____ ____/____/_______
Last First MI Date of Birth

COMMENTS: OFFICE USE

1. Reason for today's visit____
2. Are you aware of any problem? ____
3. How long since your last dental visit?__________________________________
4. What was done at that time?____
5. Previous Dentist's Name:____
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 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
Why?____
10. Have they been replaced?...YES / NO
11. How have they been replaced?
a. Fixed Bridge ____________________________When?___________________
b. Removable Bridge ________________________ When?___________________
c. Denture_________________________________ When?___________________
d. Implant_________________________________ When?___________________
12. Are you happy with the replacement? ………………………………….YES / NO
If not, explain ____
13. Would you like to know about permanent replacements? ……………...YES / NO
14. Have you ever had any problems or complications with previous dental treatment?
____
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 in your face or around your ear?...YES / NO
18. Do you have frequent headaches, neckaches or shoulder aches?.............YES / NO
19. Does food get caught in your teeth?...YES / NO
20. Are any of your teeth sensitive to: HOT? COLD? SWEETS? PRESSURE ?
21. Do your gums bleed or hurt? When?____________________________ YES / NO
22. Have you ever had gum treatment or surgery?..YES / NO
What? ____
Where? ____
When? ____
23. Do you feel your breath is offensive at times?..YES / NO
24. How often do you brush your teeth daily? 1X 2X 3X More When?__________
25. Do you use dental floss?...YES / NO
How often?____
26. Are any of your teeth: Loose? Tipped? Shifted? Chipped?
27. Are you happy with the appearance of your teeth?.................................YES / NO
28. How do you feel about your teeth in general?_______________________________
29. Have you had orthodontic work?...YES / NO
30. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike?____
31. Do you have any questions or concerns?..YES / NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S / GUARDIAN'S SIGNATURE________________________________**DATE** ____________________

DENTIST'S SIGNATURE ____ **DATE** ____________________

Dental History

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W. Carl McMillan, DMD