



Dental Medical History Form

Today's Date _____

Patient Name: First _____ Last Name _____ Nickname _____

What are your goals in coming to our practice today? _____

What is important to you in a dentist or dental practice? _____

What has been your experience with the dentist in the past? _____

Date of last radiographs (x-rays) and exam _____

Date of last hygiene/continuing care appointment (cleaning or periodontal maintenance) _____

Former Dentist _____ Phone _____

Address: Street _____ City _____ State _____ Zip _____

If you left your previous dentist, what are the reasons? _____

Have you had problems with prior dental treatment? _____

Are you experiencing any pain now? Yes No

If yes, please describe: _____

Have you ever been pre-medicated for dental treatment? Yes No

If yes, why? _____

Have you been anxious about having dental treatment? Yes No

If yes, would you be comfortable sharing why? _____

Would you like to discuss this concern with the doctor to learn about your relaxation options? _____

What concerns do you currently have with your oral health or smile? (check all that apply)

<input type="checkbox"/> Jaw/joint pain	<input type="checkbox"/> Unhappy with appearance of teeth	<input type="checkbox"/> Tooth sensitivity to hot/cold or anything else
<input type="checkbox"/> Clenching or grinding of teeth	<input type="checkbox"/> Overbite	<input type="checkbox"/> Food gets caught in between teeth
<input type="checkbox"/> Discolored teeth	<input type="checkbox"/> Underbite	If yes, where? _____
<input type="checkbox"/> Crowding/Crooked teeth	<input type="checkbox"/> Uncomfortable bite	<input type="checkbox"/> Difficulty chewing
<input type="checkbox"/> Missing teeth	<input type="checkbox"/> Old fillings (gold or silver)	If yes, where? _____
<input type="checkbox"/> Spaces in between teeth	<input type="checkbox"/> Old crowns	<input type="checkbox"/> Bad breath
<input type="checkbox"/> Loose tooth/teeth	<input type="checkbox"/> Speech problems	<input type="checkbox"/> Other _____
<input type="checkbox"/> Tooth shape or size	<input type="checkbox"/> Too much gum tissue when I smile	

Have you ever had orthodontic treatment? Yes No

If yes, when? _____

Have you ever had periodontal (gum tissue) treatment, such as deep cleanings, root planing, or periodontal surgery? Yes No

If yes, when? _____

Have you whitened your teeth in the past? Yes No

If yes, what method? _____

Are you interested in learning more about the following? (check all that apply)

<input type="checkbox"/> Teeth Whitening	<input type="checkbox"/> Tooth-colored fillings	<input type="checkbox"/> At-home oral hygiene care
<input type="checkbox"/> Orthodontic treatment	<input type="checkbox"/> Dental implants	<input type="checkbox"/> Periodontal treatment during pregnancy
<input type="checkbox"/> Veneers	<input type="checkbox"/> How to prevent periodontal disease	<input type="checkbox"/> Oral hygiene care for infants and toddlers

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