



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 exams _____

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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Diagnosis and Rationale 1 Rationale for Dental Implants 2 Generic Root Form Component Terminology 3 Diagnostic Imaging and Techniques 4 A Stress Theorem for Implant Dentistry 5 Prosthetic Options in Implant Dentistry 6 Treatment Planning Force Factors Related to Patient Conditions 7 Bone Density A Key Determinant for Treatment Planning 8 Treatment Plans Related to Key Implant Positions and Implant Number 9 Implant Body Size A Biomech Etc The International Journal of Oral & Maxillofacial Implants ,1999 **Santa Clara Computer and High-technology Law Journal** ,1995 **A Manual for Training Dental Auxiliaries in Basic Expanded Duties** ,1978 **Annals of Dentistry** ,2000

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Table of Contents Dental History Form Template

1. Understanding the eBook Dental History Form Template
 - The Rise of Digital Reading Dental History Form Template
 - Advantages of eBooks Over Traditional Books
2. Identifying Dental History Form Template
 - Exploring Different Genres
 - Considering Fiction vs. Non-Fiction
 - Determining Your Reading Goals
3. Choosing the Right eBook Platform
 - Popular eBook Platforms
 - Features to Look for in an Dental History Form Template
 - User-Friendly Interface
4. Exploring eBook Recommendations from Dental History Form Template

- Personalized Recommendations
 - Dental History Form Template User Reviews and Ratings
 - Dental History Form Template and Bestseller Lists
5. Accessing Dental History Form Template Free and Paid eBooks
 - Dental History Form Template Public Domain eBooks
 - Dental History Form Template eBook Subscription Services
 - Dental History Form Template Budget-Friendly Options
 6. Navigating Dental History Form Template eBook Formats
 - ePub, PDF, MOBI, and More
 - Dental History Form Template Compatibility with Devices
 - Dental History Form Template Enhanced eBook Features
 7. Enhancing Your Reading Experience
 - Adjustable Fonts and Text Sizes of Dental History Form Template
 - Highlighting and Note-Taking Dental History Form Template
 - Interactive Elements Dental History Form Template
 8. Staying Engaged with Dental History Form Template
 - Joining Online Reading Communities
 - Participating in Virtual Book Clubs
 - Following Authors and Publishers Dental History Form Template
 9. Balancing eBooks and Physical Books Dental History Form Template
 - Benefits of a Digital Library
 - Creating a Diverse Reading Collection Dental History Form Template
 10. Overcoming Reading Challenges
 - Dealing with Digital Eye Strain
 - Minimizing Distractions
 - Managing Screen Time
 11. Cultivating a Reading Routine Dental History Form Template
 - Setting Reading Goals Dental History Form Template
 - Carving Out Dedicated Reading Time
 12. Sourcing Reliable Information of Dental History Form Template

- Fact-Checking eBook Content of Dental History Form Template
 - Distinguishing Credible Sources
13. Promoting Lifelong Learning
- Utilizing eBooks for Skill Development
 - Exploring Educational eBooks
14. Embracing eBook Trends
- Integration of Multimedia Elements
 - Interactive and Gamified eBooks

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