Dental History

Patient Name:_____ Date of Birth:_____

What is the reason for your visit today?_____

_____

_____

Date of: Last dental visit_____ Last dental cleaning_____ Last x-rays_____

What was done at your last dental visit?_____

Previous dentist's name:_____ Telephone:_____

Address:_____ State:_____ Zip:_____

How often do you have dental examinations?_____

Check (✓) if you currently have problems with any of the following:

☐ Broken Filling
☐ Toothache
☐ Loose Tooth
☐ Grinding Teeth
☐ Clicking / Pain Jaw
☐ Sleep Apnea
☐ Sensitivity to Hot and/or Cold
☐ Sensitivity to Biting
☐ Sensitivity to Sweets
☐ Sores or Growths in Mouth
☐ Coldsores
☐ Herpes
☐ Bleeding Gums
☐ Food Collection Between Teeth
☐ Dry Mouth

Check (✓) if you have had problems with any of the following:

☐ Have you been told you have periodontal disease or gum disease?_____

☐ Have you been treated for periodontal disease or gum disease?_____

☐ Do you smoke?_____ ☐ Previous Smoker?_____ ☐ Do you chew / smokeless tobacco?_____

☐ Do you have dental implants?_____ ☐ Any Dental Surgeries?_____

☐ Do you have missing teeth?_____ ☐ Do you wear dentures or partials?_____

☐ Have you had braces?_____

Any dental concerns?_____

_____

_____

I certify that the above information is complete and accurate.

Signature:_____ Date:_____

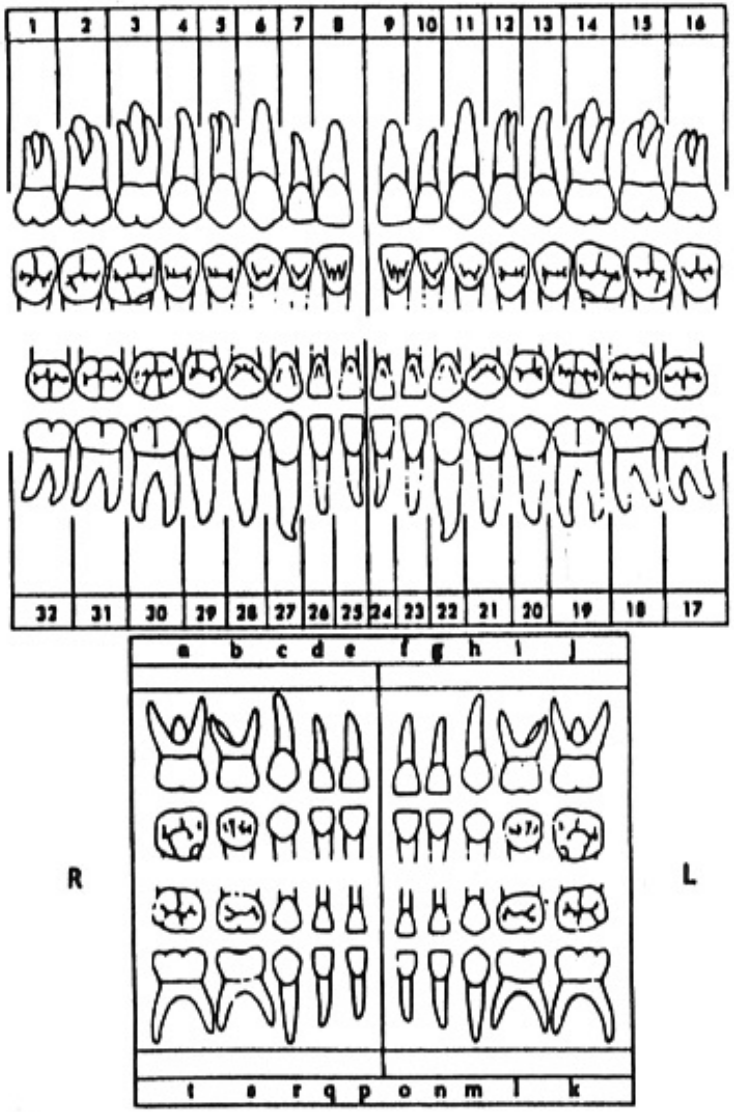
Patient Name:_____

PRIMARY
DENTIST:_____ DATE:_____

INITIAL CLINICAL EXAMINATION
EXISTING CONDITIONS

TO BE COMPLETED BY OFFICE PERSONNEL ONLY

CARIES SOLID RED AMALGAMS AND GOLD SOLID BLUE
COMPOSITES OUTLINE IN BLUE



	NORMAL	ABNORMAL
LYMPH NODES		
PHARYNX		
TONSILS		
SOFT PALATE		
HARD PALATE		
FLOOR OF MOUTH		
LIPS		
SKIN		
TMJ		
TONGUE		
VESTIBULES		
BUCCAL MUCOSA		
ORAL HYGIENE	☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR	
CALCULUS	☐ NONE ☐ LITTLE ☐ MODERATE ☐ HEAVY	
GINGIVA	☐ FIRM ☐ MILD ☐ MODERATE ☐ POCKETED	
MOBILITY (IN GENERAL)		
OCCLUSION: I II III		

CHIEF COMPLAINT		
TYPE OR AREA	DATE INSERTED	CONDITION

OTHER ORAL FINDINGS

TREATMENT RECOMMENDATIONS _____

_____

_____

_____