Patient Dental History

Patient Name: ___________________________________

Parent/Guardian Name (if minor): _____________________

Email Address: ___________________________________

Name of Previous Dentist: _____________________

Date of Last Dental Exam: _____________________

Date of Last Dental Cleaning: __________________

Cleaning Frequency: _________________________

Patient Date of Birth: __________________

Emergency contact Information

Name: _______________________

Phone number: ________________

Relationship to Patient: __________

Have you ever been told you have gum or periodontal disease **YES** **NO**

If yes, have you had treatment? YES NO If yes, when: ________

Do you have a family history of any of the following conditions?:

Diabetes, including gestational YES NO

Periodontal Disease YES NO

Have you had or are you currently experiencing any of the following?

Sensitive teeth? YES NO

Pain in your mouth? YES NO

Sores or lumps in or near your mouth? YES NO

Clicking, popping, or other difficulty with your jaw? YES NO

Head, neck, or jaw injuries? YES NO

Difficult extractions in the past? YES NO

Orthodontic treatment? YES NO

Have a denture or a partial denture? YES NO

Have you ever had a bad experience at the Dental Office? If yes, please describe:

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How did you hear about our office? Internet/Website Insurance Company Drive By

Family/Friend: _________________ NB Cinema Ad New Resident Packet Other: ____________