

Adult Dental History Form

Patient Personal Information

Name:	Age:
DOB:	E-mail:

Dental History

Previous Dentist:	
Address:	
Date of most recent dental exam:	Date of most recent x-rays:
I routinely see my dentist every: <input type="checkbox"/> 3 mo. <input type="checkbox"/> 4 mo. <input type="checkbox"/> 6 mo. <input type="checkbox"/> 12 mo. <input type="checkbox"/> Not Routinely	
WHAT IS YOUR IMMEDIATE CONCERN?	

Please Answer Yes or No to the Following:

Are you fearful of dental treatment? Scale of 1 to 10 (very)	
Personal History	
Have you had an unfavorable dental experience? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had complications from past dental treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had trouble getting numb or reactions to local anesthetic? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you currently have dentures, dental implants, or partials? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you premedicate for your dental appointments? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please explain:	
Smile Characteristics	
Are you self conscious about your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever whitened (bleached) your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is there anything about the appearance of your teeth that you would like to change? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Bite and Jaw Joint	
Do you grind or clench your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have problems with your jaw joint or facial muscles? (pain, sounds, limited opening, locking, popping) <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have tension headaches or sore teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you wear or have you ever worn a bite appliance? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you play any sports? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so do you wear an athletic mouth guard? <input type="checkbox"/> Yes <input type="checkbox"/> No
Tooth Structure	
Do you have a dry mouth? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are any teeth sensitive to hot, cold, biting or sweets? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are any of your teeth causing you pain? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Please Answer Yes or No to the Following:

Gum and Bone					
Have you ever been diagnosed or treated for periodontal disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do your gums bleed when brushing, flossing or eating?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you experience bad breath?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you suffer from mouth ulcers or sores?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you snore or have been diagnosed with sleep apnea?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

Patient Signature:
Date:
Parent, Guardian, Legal Representative Signature:
Doctor's Signature:
Date: