

New Patient Dental History

Reason for coming to see the dentist:

Are you currently in pain/discomfort? Yes No

If Yes, please explain: _____

Are your teeth sensitive to heat, cold, or anything else? Yes No

If Yes, please explain: _____

Do you require antibiotics before dental treatment? Yes No

Would you describe your current dental health as: Good Fair Poor

Have you ever had a serious/difficult problem associated with any previous dental work? Yes No

If Yes, please explain: _____

Do you floss daily? Yes No

Do you brush daily? Yes No

What type of bristles are on your toothbrush? Hard Medium Soft

Do your gums ever bleed? Yes No

Have you ever had periodontal disease? Yes No

Have you ever had gum or periodontal treatment? Yes No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? Yes No

If Yes, please explain: _____

Are you aware of any habits such as grinding or clenching? Yes No If so, do you wear a night guard? Yes No

Have you ever had orthodontic treatment (braces)? Yes No If so, do you wear retainers? Yes No

Do you have any loose teeth? Yes No Do you still have your wisdom teeth? Yes No

Would you like fresher breath? Yes No Would you like whiter teeth? Yes No

Are you happy with the way your smile looks? Yes No

If not, what would you change? _____

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical/dental status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

Signature _____

Date _____

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Office Use Only

Doctors Comments:

