John WHITE DDS

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MASTER ACADEMY OF GENERAL DENTISTRY FELLOW ACADEMY OF DENTISTRY INTERNATIONAL

Dental Health History

INSTRUCTIONS: *If hand writing, please fill in **black** pen ink only.*

Are you presently changing dentists? ☐ Yes ☐ No

If yes, so that we may serve you better, why are you changing dentists?

Date of last dental visit: _____/_____/_____

Name of previous dentist or place you receive dental care:

Telephone No.: ( )

What, if anything, would you like us to be aware of so that we can make your visit most pleasant?

How many times per week do you brush your teeth?

☐ Never ☐ 1-6 ☐ 7-13 ☐ 14 or more

How many times per week do you floss your teeth?

☐ Never ☐ 1-6 ☐ 7-13 ☐ 14 or more

Which of the following hygiene products do you use?

☐ Manual toothbrush ☐ Power toothbrush ☐ Denture brush
☐ Fluoride toothpaste ☐ Tartar control toothpaste ☐ Flossing aid(s)
☐ Fluoride mouth rinse ☐ Fluoride gel application ☐ Water-Pik®

Do you now have, or have you been treated in the past for the following?

☐ Gum disease / periodontal disease ☐ Tooth decay ☐ Dry mouth
☐ Headache when you wake up ☐ Injury to teeth/jaw/face ☐ Sore jaw muscles
☐ Sensitive teeth ☐ Tooth grinding or clenching ☐ Braces
☐ Painful jaw joints ☐ Crowns ☐ Mouth ulcers/sores
☐ Lumps or growths in the head/neck/mouth ☐ Open spaces between teeth ☐ Dental Implants
☐ Removal of wisdom teeth ☐ Tooth whitening/bleaching ☐ Root canal treatment
☐ Complete or partial dentures ☐ Bridges

Have you ever experienced the following during dental treatment?

- ☐ Special Apprehension or Phobia
- ☐ Fainting spells
- ☐ Nitrous oxide / laughing gas
- ☐ Unusual reactions to dental anesthetics
- ☐ Sedation with tablets
- ☐ I.V. Sedation / twilight sleep

If you could change anything about your smile, what would you change?

Are there any special problems with your mouth or teeth that you would like for us to be aware of?

We want to know what is important to you. If you'd like more information on any of the following, please check all that apply:

- ☐ Whiter teeth
- ☐ Straighter teeth
- ☐ Stronger teeth
- ☐ Replace missing teeth
- ☐ Avoiding dental emergencies
- ☐ Fewer well-planned appointments
- ☐ Monthly payment plans

For denture wearers:

Which type of denture do you wear? ☐ Upper ☐ Lower

How many sets of dentures have you had made since the loss of your natural teeth? _____

Do you use denture adhesive? ☐ Upper ☐ Lower

Is your experience with denture adhesive? ☐ Good ☐ Bad ☐ Don't use it

How old is your current denture? _____

How many relines have you had? _____ Date of last reline: _____/_____/_____

Are you able to eat *any* food you want with your dentures? ☐ Yes ☐ No

Do you visit the dentist yearly to check your dentures and your mouth? ☐ Yes ☐ No

What do you miss most about your natural teeth?

I acknowledge that I have answered these questions accurately and truthfully to the best of my knowledge. I agree to report any changes in my dental health to this practice at the earliest possible time.

Signature of patient, or parent, or guardian (responsible party): _____

Print Name: _____ Relationship to the patient: _____ Date: _____/_____/_____