New Patient Dental History

What would you like us to do today? ____________________

Are you in dental discomfort today? ____________________

Former Dentist: ____________ Address: ____________ Phone: ____________

Reason for change in dentist: ____________________

Date of last dental care: ____________ Date of last x-rays: ____________

Check if you have or have had problems with any of the following...

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Clicking or Popping Jaw
- ☐ Grinding or Clenching Teeth
- ☐ Food Collecting Between Teeth
- ☐ Loose Teeth or Broken Fillings
- ☐ Periodontal Treatment
- ☐ Sores or Growths in Mouth
- ☐ Sensitivity to Hot
- ☐ Sensitivity to Cold
- ☐ Sensitivity to Sweets
- ☐ Sensitivity when Biting

How often do you brush? ____________ Floss? ____________

How do you feel about the appearance of you teeth? ____________________

Have you experienced an adverse reaction during or in conjunction with medical or dental treatment? ☐ Yes ☐ No

If yes, please explain: ____________________

Any other information we should know about your dental health or previous treatment? ____________________

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Please Initial ____________