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Adult Dental History Form

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Birth Date: _____

Previous Dentist

Previous Dentist's Name,Address, City, State, Zipcode, Telephone

_____

_____

_____

_____

How long were you a patient there? _____

Frequency of dental care:

◯ Regular (every 3-6 months) ◯ Periodic (every 7-12 months) ◯ Infrequent (more than every 12 months)

◯ Emergency (for pain/problem management)

Please describe your daily oral health routine.

_____

_____

_____

_____

Please describe any dental concerns.

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_____

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_____

Please tell us why you have chosen our office for your dental care.

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_____

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_____

Adult Dental History Form (Continued)

Please check all that apply:

- ☐ Have dental pain or discomfort
- ☐ Have had upsetting dental experience
- ☐ Have nervous feelings about receiving dental treatment
- ☐ Have sensitivity to temperature, pressure, or food/drink
- ☐ Have unpleasant taste or odor in my mouth
- ☐ Have gums which hurt or bleed when brushing or flossing
- ☐ Have been told I have gum disease
- ☐ Have been treated for gum disease
- ☐ Have active dental disease
- ☐ Have family history of gum disease
- ☐ Have lost permanent (adult) teeth other than wisdom teeth
- ☐ Have desire to learn how to control my dental disease and retain my teeth
- ☐ Have noticed loose teeth or changes in my bite
- ☐ Have food catching between my teeth
- ☐ Have had my bite adjusted
- ☐ Have worn a bite splint or night guard
- ☐ Have experienced a serious injury to my mouth or head
- ☐ Have had orthodontic treatment (i.e. braces or retainers)
- ☐ Have had oral surgery (i.e. wisdom teeth removed)
- ☐ Have been told that I require premedication with antibiotics prior to dental treatment
- ☐ Have concerns about the finances required to achieve excellent oral health

Please explain any checked responses above:

_____

_____

_____

_____

Response Date: ____/____/_____