DENTAL HISTORY

Name _____ Nickname _____ Age _____

Referred by _____ Previous Dentist _____

I routinely see my dentist every: □3mo. □4mo. □6mo. □12mo. □Not routinely

Date of most recent dental exam ___/____/____ Date of most recent x-rays ___/____/____

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful on a scale of 1 (least) to 10 (most)?_____
2. Have you had an unfavorable dental experience? _____
3. Do your gums bleed or are they painful when brushing or flossing? _____
4. Do you have problems with your jaw joint? _____
5. Do you have difficulty chewing hard or dry foods? _____
6. In the past 5 years, have your teeth become more crooked, crowded or overlapped? _____
7. Is there anything about the appearance of your teeth that you would like to change (shape, color, size)? _____
8. Would you like information on Financing your dental treatment? If yes, what is your credit score? _____
9. Is this your first consultation regarding the concerns you'd like to discuss today? _____

PHARMACY INFORMATION

Name of Pharmacy: _____ Location: _____

Patient's Signature _____ Date _____