Acquaintance Form and Dental History

By asking these questions we will be able to better understand your previous dental experiences, any concerns you may have, and dental goals short term and long term.

Administrative Questions:

Patient name: _____ Date: _____

Whom may we thank for inviting you to our practice? _____

How long has it been since you have seen a dentist? _____

How long has it been since your last hygiene appointment? _____

Previous Dentist_____ City, State _____

Medical questions:

Have you been advised by a physician to pre-medicate with an antibiotic prior to having dentistry? _____

Who prescribed the antibiotic? _____

Why was the antibiotic prescribed? _____

Emergency contact person_____ Phone number _____

==========

How can we help you? _____

Any major concerns that require immediate attention?_____

*How long has that been a problem? _____

*Have you tried anything for the problem so far? _____

Do you have any long term dental goals for your oral health and or appearance that you would like us to know about? _____
_____

Is there anything we can do to make your visits more comfortable? _____

Do you suffer anxiety or gagging during dental procedures? _____

Do you have any questions you would prefer to ask the doctor privately? _____

Dental History:

Have you seen any dental specialists? _____Treatment? _____

Last Dental visit was for? _____

Page 2 other side →

Have you ever experienced any unfavorable reaction to dentistry?_____

Do you have dental implants? _____

Do you wear partials or dentures? _____ If so, how old are they? _____ Are they comfortable? _____

Are you interested in having any teeth replaced? _____

What has been the average time between your hygiene visits?_____

How often do you brush your teeth? _____ Do you avoid brushing any part of your mouth? _____

Have you ever been treated for periodontal (gum) disease? _____

Do you ever notice some bleeding or tenderness of your gums? _____

Have your parents experienced gum disease or tooth loss? _____

Have you been told by your previous dentist you have gum disease? _____

Do you have any areas in your mouth that are sensitive to hot/cold liquids? If so, where? _____

Do you have any sores, lumps, irritations or burning sensation anywhere in your mouth? _____

Do you get frequent episodes of cold sores or mouth ulcers? _____

Do you chew on one side/both sides or have difficulty eating? _____

Do you have a problem with excessive food getting caught between your teeth? _____

Do you get frequent headaches? _____

Do you have any jaw discomfort? _____

Do you have difficulty in opening your mouth widely? _____

Have you ever had a night guard made for you? _____

Have you ever been treated for sleep apnea?_____

Have you been told you snore?_____

Have you ever had prolonged bleeding following extractions in the past? _____

Have you ever worn braces or a retainer to straighten your teeth? _____

Are you aware of any broken teeth or fillings? _____

How do you feel about the color of your teeth? _____

Is there anything about the appearance and or function of your teeth you would like changed? _____

Date _____ Patient Signature _____

Date _____ Staff Member's Signature _____