Patients Name:______________________

Patient Dental History

Reason for today's visit?____
What are your concerns regarding your mouth?___________________________________
Former Dentist: ____________________________Reason for Change_______________
Date of Last Dental Visit___________________ Last Cleaning_____________________
Have you had problems with previous dental treatment?___________________________
Are you nervous about seeing a dentist? (Please explain)__________________________
What kind of tooth brush do you use? Electrical_______ Manual_________
How often do you brush? ___________Floss?________

Check if you have had any of the following:

- ○ Gums bleed with brushing/flossing
- ○ Teeth sensitive to hot/cold liquid/food
- ○ Teeth sensitive to sweet/sour liquid/food
- ○ Pain to any teeth
- ○ Sores/lumps in or near mouth
- ○ Head, neck or jaw injuries
- ○ Frequent headaches
- ○ Clench/grind teeth
- ○ Clicking/Popping jaw
- ○ Pain in jaw joint, ear, side of face
- ○ Difficulty chewing
- ○ Difficulty opening/closing
- ○ Bite lip/cheek frequently
- ○ Sensitivity when biting
- ○ Facial/jaw injury
- ○ Deep cleaning
- ○ Any difficult extractions
- ○ Prolonged bleeding after extraction
- ○ Orthodontic treatment
- ○ Periodontal surgery
- ○ Mouth dryness
- ○ Received oral hygiene instruction
- ○ Wear dentures or partials
  Date of placement_____________
- ○ Do you like your denture/partial? Yes___No___

What are your dental priorities? Check all that apply:

- ○ Comprehensive dental care
- ○ Emergency dental care
- ○ Improve the appearance of my teeth
- ○ Other, please specify______________________________

Dr. Notes: ____
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I certify that I have read and understand the medical & dental information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. If I ever have any changes in my health, or medications, I will inform Beautiful Smiles Dental and staff at my next appointment.

__________________________________ ________________________
Signature of patient or legal guardian Date

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PLEASE TURN TO NEXT PAGE