EXPRESS\DENHIST.EPD

PATIENT NAME:_____
LAST FIRST M.I.

Purpose of initial visit:_____
Are you aware of a problem?_____
How long since your last dental visit?_____
What was done at that time?_____
Previous dentist's name:_____Location:_____

Date of Birth
/ /

PLEASE CIRCLE THE APPROPRIATE ANSWER

NO	Yes	Have you made regular visits?
		How often?_____
NO	Yes	Have X-Rays been taken in the last two years?
NO	Yes	Do you have all your teeth (except wisdom teeth)?
NO	Yes	If no, have missing teeth been replaced?
NO	Yes	Are you happy with the replacement?
		If no, please explain._____
YES	No	Would you like to know about permanent replacements?
YES	No	Do you clench or grind your teeth?
YES	No	Does your jaw click or pop?
YES	No	Have you experienced pain or soreness around your ear or the muscles of your face?
YES	No	Does food get caught between your teeth on a regular basis?
YES	No	Are any of your teeth sensitive to hot?
YES	No	Cold?
YES	No	Sweets?
YES	No	Pressure?
YES	No	Do your gums bleed or hurt?
		If yes when?_____
NO	Yes	Do you use dental floss?
NO	Yes	On a daily basis?
YES	No	Have you ever had gum treatment or surgery?
		What type?_____
		What areas?_____
		When?_____
NO	Yes	Are you happy with the appearance of your teeth?
YES	No	Have you experienced any problems or complications with previous dental treatment?
		If yes, what?_____
YES	No	Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike?
		If yes, what?_____
YES	No	Do you prefer dental treatment WITHOUT a local anesthetic (novocaine, xylocaine, carbocaine, etc.)?
YES	No	Have you had dental treatment using nitrous oxide (laughing gas)?
YES	No	Do you wish to try nitrous oxide or would you like to use it again?
YES	No	Do you have any questions or concerns?

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT SIGNATURE _____

RELATIONSHIP (If not patient)_____ **DATE:** _____

DENTAL ALERT

DENTAL HISTORY