IntegrityDental

DENTAL HISTORY

Patient Name: _____ Birth Date: _____ Today's Date: _____

When was your last dental exam? _____ When was your last dental cleaning? _____
Name of your previous dentist / dental office: _____
Reason for leaving: _____
How did you hear about our office: _____
What can we do to help you feel comfortable: _____
_____
What can we avoid to help you feel comfortable: _____
_____

Reason for today's visit: _____

Do you have or have you ever had any of the following:

○Y○N Abscesses	○Y○N Fillings	○Y○N Sedation treatment
○Y○N Aesthetic concerns	○Y○N Jaw discomfort	○Y○N Sleep apnea
○Y○N Bad breath	○Y○N Nightguard	○Y○N Snoring
○Y○N Bleeding gums	○Y○N Oral cancer	○Y○N Swelling in the mouth
○Y○N Bridges	○Y○N Oral lesions / sores	○Y○N Taste dysfunction
○Y○N Complete dentures	○Y○N Orthodontic treatment	○Y○N Temperature sensitivity
○Y○N Complications from treatments	○Y○N Pain when chewing	○Y○N Tooth extractions
○Y○N Crowns	○Y○N Partial dentures	○Y○N Tooth mobility
○Y○N Deep cleanings	○Y○N Periodontal surgery	○Y○N Trauma to teeth
○Y○N Dental anxiety	○Y○N Retainers	○Y○N Wisdom teeth removal
○Y○N Dental implants	○Y○N Root canal treatment	○Y○N Whitening treatment
○Y○N Dry mouth	○Y○N Salivary dysfunction	○Y○N Other

Patient comments / concerns regarding anything listed or not listed on this form: _____
_____
_____

Do you floss your teeth: ☐Daily ☐Few times / week ☐Few times / month ☐Few times / year ☐Never
Do you brush your teeth: ☐Twice daily ☐Once daily ☐Few times / week ☐Few times / month ☐Rarely
Do you brush with: ☐Manual toothbrush ☐Electric toothbrush ☐Other

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect or incomplete information can be dangerous to my or the patient's health. It is my responsibility to inform the dental office of any changes in my / the patient's dental condition.

Signature of Patient / Legal Guardian: _____

Doctor Use Only