

PATIENT HEALTH HISTORY

In order to help me render the proper dental services to you, please answer the following questions. Note the space for remarks for any answers that require clarification or any other information you think I should have. Thank you for your cooperation.

DATE _____

NAME _____

First

Middle Initial

Last

ADDRESS _____ ZIP _____

HOME PHONE _____ CELL PHONE _____

BUSINESS NAME _____ PHONE # _____

OCCUPATION _____ E-MAIL ADDRESS _____

DATE OF BIRTH _____ SEX _____ HEIGHT _____ WEIGHT _____

MARITAL STATUS _____ SPOUSE'S NAME _____

NAME OF DENTAL INSURANCE _____ PHONE # _____

SOCIAL SECURITY # _____ REFERRED BY _____

IN CASE OF EMERGENCY NOTIIFY _____ PHONE # _____

DENTAL HISTORY

Reason for visit? _____

When was your last dental visit? _____

Have your past dental experiences in a dental office always been positive? _____

How often do you brush your teeth? _____

How often do you floss? _____

Do your gums bleed while brushing? _____ flossing? _____

Do you avoid brushing any part of your mouth because of pain? _____

If yes, what part? _____

Do you feel twinges of pain when your teeth come in contact with?

Hot foods or liquids? _____ Sweets? _____

Cold foods or liquids? _____ Sours? _____

Do you feel pain to any of your teeth when brushing or flossing? _____

Do you chew on only one side of your mouth? _____

If yes, explain: _____

Do your gums feel tender or swollen? _____

Does food get caught between your teeth? Yes ___ No ___

Do you clench your teeth while sleeping? _____ During the day? _____

Do you grind your teeth while sleeping? _____ During the day? _____

Do your jaws feel tired? _____