Name ____ Date of Birth ________________

Your purpose for today's visit ____

When was the last time you visited your previous dentist? ____

Did you have your teeth cleaned? □ Yes □ No Were x-rays taken? □ No □ Yes

Previous Dentist's Name ____

Address ____ Phone No____________________

Please check the appropriate box - Please explain/give details as needed.

1. Do you like the appearance of your teeth and smile? □ Yes □ No
   a. Explain Likes & Dislikes ____

   ____
2. Do you feel at times your breath can be offensive? □ Yes □ No □ Don't Know
3. Were your previous dental visits regular? □ Yes □ No □ Don't Know
4. Have you ever had any complications or problems following dental treatment? □ Yes □ No □ Don't Know
5. Any Missing teeth? □ Yes □ No □ Don't Know
   a. Have the missing teeth been replaced? □ Yes □ No □ Don't Know
   b. How were they replaced?
      1. Fixed Bridge 2. Removable Bridge/Partials 3. Denture Year Replaced ______________
   c. Are you satisfied with the replacements? □ Yes □ No
   d. If No; do you want to learn about new or alternative replacement options? □ Yes □ No
6. Do you grind your teeth or clinch your jaw? □ Yes □ No □ Don't Know
7. Does your jaw "pop" when you open your mouth? □ Yes □ No □ Don't Know
8. Do you get frequent head, neck or backaches? □ Yes □ No
9. Does food get caught in your teeth? □ Yes □ No □ Don't Know
10. Have you noticed if your teeth are sensitive to: □ Hot □ Cold □ Sweets □ Pressure □ No
11. When you brush, do your gums bleed or hurt? □ Yes □ No □ Don't Know
12. Do you floss? □ Yes □ No If Yes, how often? ____
13. Do you have any of the following concerns with your teeth: □ Loose □ Chipping □ Shifting □ Crowding
14. Have you ever had gum surgery? □ Yes □ No If yes, when ________________________________
15. Have you ever had braces (Orthodontics)? □ Yes □ No □ Don't Know
16. Have you ever has an unpleasant dental experience? □ Yes □ No ____________________________
17. Is there anything in dentistry that you strongly dislike? ____________________________________

I DECLARE THAT THE ABOVE INFORMATION GIVEN IS COMPLETE AND ACCURATE.

Patient's/Guardian's Signature: ____ Date ________________

DENTAL HISTORY

Office of Dr. Dan Fong, DDS