



Dental Medical History Form

Today's Date _____

Patient Name: First _____ Last Name _____ Nickname _____

What are your goals in coming to our practice today? _____

What is important to you in a dentist or dental practice? _____

What has been your experience with the dentist in the past? _____

Date of last radiographs (x-rays) and exam _____

Date of last hygiene continuing care appointment (cleaning or periodontal maintenance) _____

Former Dentist _____ Phone _____

Address: Street _____ City _____ State _____ Zip _____

If you left your previous dentist, what are the reasons? _____

Have you had problems with prior dental treatment? _____

Are you experiencing any pain now? ☐ Yes ☐ No

If yes, please describe _____

Have you ever been pre-medicated for dental treatment? ☐ Yes ☐ No

If yes, why? _____

Have you been anxious about having dental treatment? ☐ Yes ☐ No

If yes, would you be comfortable sharing why? _____

Would you like to discuss this concern with the doctor to learn about your relaxation options? _____

What concerns do you currently have with your oral health or smile? (check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Jaw joint pain | <input type="checkbox"/> Unhappy with appearance of teeth | <input type="checkbox"/> Tooth sensitivity to hot/cold or anything else |
| <input type="checkbox"/> Clenching or grinding of teeth | <input type="checkbox"/> Overbite | <input type="checkbox"/> Food gets caught in between teeth |
| <input type="checkbox"/> Discolored teeth | <input type="checkbox"/> Underbite | If yes, where? _____ |
| <input type="checkbox"/> Crowding/Crooked teeth | <input type="checkbox"/> Uncomfortable bite | <input type="checkbox"/> Difficulty chewing |
| <input type="checkbox"/> Missing teeth | <input type="checkbox"/> Old fillings (gold or silver) | If yes, where? _____ |
| <input type="checkbox"/> Spaces in between teeth | <input type="checkbox"/> Old crowns | <input type="checkbox"/> Bad breath |
| <input type="checkbox"/> Loose tooth/teeth | <input type="checkbox"/> Speech problems | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Tooth shape or size | <input type="checkbox"/> Too much gum tissue when I smile | |

Have you ever had orthodontic treatment? ☐ Yes ☐ No

If yes, when? _____

Have you ever had periodontal (gum tissue) treatment, such as deep cleanings, root planing, or periodontal surgery? ☐ Yes ☐ No

If yes, when? _____

Have you whitened your teeth in the past? ☐ Yes ☐ No

If yes, what method? _____

Are you interested in learning more about the following? (check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Teeth Whitening | <input type="checkbox"/> Tooth-colored fillings | <input type="checkbox"/> At-home oral hygiene care |
| <input type="checkbox"/> Orthodontic treatment | <input type="checkbox"/> Dental implants | <input type="checkbox"/> Periodontal treatment during pregnancy |
| <input type="checkbox"/> Veneers | <input type="checkbox"/> How to prevent periodontal disease | <input type="checkbox"/> Oral hygiene care for infants and toddlers |