

# Welcome

## William Glover, DMD, LLC DENTAL HISTORY

ANESTH.

MED. ALERT

Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_  
Last First MI

Date of Birth: \_\_\_\_\_ Male: \_\_\_\_\_ Female: \_\_\_\_\_

1. Purpose of intial visit \_\_\_\_\_  
\_\_\_\_\_
  2. Are you aware of any problem? \_\_\_\_\_
  3. How long since your last dental visit? \_\_\_\_\_
  4. What was done at that time? \_\_\_\_\_  
\_\_\_\_\_
  5. Previous dentist's name: \_\_\_\_\_  
Address: \_\_\_\_\_ PH: \_\_\_\_\_
  6. When was the last time you teeth were cleaned? \_\_\_\_\_
- CIRCLE THE APPROPRIATE ANSWER, IF YOU DON'T KNOW THE ANSWER., PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.**
7. Have you made regular visits?.....YES NO  
How often? \_\_\_\_\_
  8. Were dental x-rays taken.....YES NO
  9. Have you lost any teeth or have any teeth been removed.....YES NO  
Why? \_\_\_\_\_
  10. Have any been replaced?.....YES NO
  11. How have they been replaced?  
a. Fixed bridge \_\_\_\_\_ Age \_\_\_\_\_  
b. Removable bridge \_\_\_\_\_ Age \_\_\_\_\_  
c. Denture \_\_\_\_\_ Age \_\_\_\_\_

**COMMENTS**

12. Are you unhappy with the replacement.....YES NO  
If yes, explain: \_\_\_\_\_
13. Would you like to know about permanent replacements?.....YES NO
14. Have you ever had any problems or complications with previous dental treatment?...YES NO  
If yes, explain \_\_\_\_\_
15. Do you clench or grind your teeth?.....YES NO
16. Does your jaw click or pop?.....YES NO
17. Have you ever experienced any pain or soreness in the muscles in your  
face or around your ear?.....YES NO
18. Do you have frequent headaches, neckaches, or shoulder aches?.....YES NO
19. Does food get caught in your teeth?.....YES NO
20. Are any of your teeth sensitive to: Hot? \_\_\_\_\_ Cold? \_\_\_\_\_ Sweets? \_\_\_\_\_ Pressure? \_\_\_\_\_
21. Do your gums bleed or hurt?.....YES NO  
When? \_\_\_\_\_
22. How often do you brush your teeth? \_\_\_\_\_ When? \_\_\_\_\_
23. Do you use dental floss?.....YES NO  
How often? \_\_\_\_\_
24. Are any of your teeth loose, tipped, shifted, or chipped?.....YES NO
25. Are you unhappy with the appearance of your teeth?.....YES NO
26. How do you feel about your teeth in general? \_\_\_\_\_
27. Do you feel your breath is offensive at times?.....YES NO
28. Have you ever had gum treatment or surgery?.....YES NO  
What? \_\_\_\_\_  
Where? \_\_\_\_\_  
When? \_\_\_\_\_
29. Have you had any orthodontic work? \_\_\_\_\_
30. Have you had any unpleasant dental experiences or is there anything about dentistry that you  
strongly dislike? \_\_\_\_\_
31. Do you have nay questions or concerns?.....YES NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE  
PATIENT'S/GUARDIAN'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
DENTIST'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_