Dental History Form

South Waterfront Dental
Todd L. Beck, DMD

Patient name: ______________________________ (LAST / FIRST / MI) Preferred name: ____________ Birth Date: ____________

Purpose of today's visit: ______________________________

Any other dental problems or concerns you would like addressed? ______________________________

PAST DENTAL EXPERIENCE

Previous dentist's name: ______________________________

Office name, city, phone number: ______________________________

How often do you go to the dentist? ______________________________

Date of last dental visit: ______________________________

Date of last cleaning: ______________________________

Date of last dental x-rays: ______________________________

Have you had complications with previous dental treatment? ☐ No ☐ Yes ____________

Do you have any specific goals with your dental treatment? ☐ No ☐ Yes ____________

Is there anything you strongly dislike about coming to the dentist? ☐ No ☐ Yes ____________

Is there anything you would like to discuss with Dr. Beck privately? ☐ No ☐ Yes ____________

PERIODONTAL HISTORY

How often do you brush your teeth? ______________________________

How often do you floss? ______________________________

Have you ever had a full periodontal charting? ☐ No ☐ Yes ____________

Have you ever needed: deep cleaning, SRP, scaling or root planing? ☐ No ☐ Yes ____________

Have you ever had gum treatment, surgery or grafting? ☐ No ☐ Yes ____________

Do your gums bleed when you brush or floss? ☐ No ☐ Yes ____________

What kind of toothbrush do you use? ☐ No ☐ Yes ____________

Do you suffer from bad breath (halitosis)? ☐ No ☐ Yes ____________

DENTAL HISTORY

Do you currently have a toothache, sensitivity or discomfort? ☐ No ☐ Yes ____________

If yes describe pain, area, duration: ______________________________

Do you have any loose teeth? If yes describe area: ☐ No ☐ Yes ____________

Does food get caught in your teeth? If yes where? ☐ No ☐ Yes ____________

Have you ever had braces? If yes when and for how long? ☐ No ☐ Yes ____________

Are your wisdom teeth removed? If yes how many and at what age? ☐ No ☐ Yes ____________

Any other teeth removed or lost (other than wisdom teeth)? ☐ No ☐ Yes ____________

If yes are you interested in a permanent replacement? ☐ No ☐ Yes ____________

TMJ PROFILE

Do you clench or grind your teeth? ☐ No ☐ Yes ____________

Does your jaw pop or click? ☐ No ☐ Yes ____________

Do you have pain or soreness in your face muscles or around your ears? ☐ No ☐ Yes ____________

Do you have frequent headaches, neck aches or shoulder aches? ☐ No ☐ Yes ____________

Do you or have you worn a splint or night guard? ☐ No ☐ Yes ____________

COSMETIC PROFILE

Do you have any chipped/broken teeth? ☐ No ☐ Yes ____________

Are you interested in repair? ☐ No ☐ Yes ____________

Are you happy with the appearance of your teeth? ☐ No ☐ Yes ____________

Are you interested in changing the appearance? ☐ No ☐ Yes ____________

If yes, describe changes you would like made to your teeth/smile: ______________________________

Patient/guardian signature indicates the above information is complete and accurate.

✗ ______________________ Patient/Guardian Signature

______________________ EFDA / RDH Review

______________________ Dentist Review

____________ Date