



whitmiredmd.com

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## DENTAL HISTORY

Former dentist \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Date of last dental visit \_\_\_\_\_ Date of last dental x-rays \_\_\_\_\_

Reason for visit \_\_\_\_\_

**Please check yes or no for the following questions. If yes, please fill in details.**

**YES NO**

Are you presently in any dental pain?  
Please describe \_\_\_\_\_

Have you ever experienced any unfavorable reaction to dentistry?  
What? \_\_\_\_\_

Have you ever had any bad reaction to a dental anesthetic?  
When? \_\_\_\_\_

Do you brush and floss on a regular basis?  
\_\_\_\_\_

Have you been given good home care instructions?  
When? \_\_\_\_\_

Do you have any untreated dental problems that you are aware of?  
\_\_\_\_\_

Have you ever had orthodontic treatment?  
When? \_\_\_\_\_

Have you lost any teeth?  
From what cause? \_\_\_\_\_

Have you worn a plate/nightguard?  
\_\_\_\_\_

Do you have any loose teeth? Have you ever heard of Periodontal Disease?  
\_\_\_\_\_

Does your gums bleed when you brush your teeth?  
\_\_\_\_\_

Do you have any growths or swellings in your mouth?  
For how long? \_\_\_\_\_

Is any part of your mouth sensitive to temperature, pressure?  
Where? \_\_\_\_\_

Does food catch between your teeth?  
Which area? \_\_\_\_\_

Are you aware of clenching your teeth during daytime hours?  
How often? \_\_\_\_\_



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**YES**    **NO**

- Have you ever been told that you grind your teeth during sleep?  
How often? \_\_\_\_\_
- Have you experienced clicking of the jaw?  
Which side? \_\_\_\_\_
- Do you have any difficulty opening/closing your mouth?  
\_\_\_\_\_
- Do you have any unpleasant taste or odor in your mouth?  
\_\_\_\_\_
- Are you satisfied with your teeth and appearance?  
\_\_\_\_\_
- If you are wearing dentures, are they satisfactory?  
\_\_\_\_\_

**Additional Questions:**

What is most important to you in a dentist?  
\_\_\_\_\_

What do you expect from our office? \_\_\_\_\_

What do you like best about your previous office? Dentist? Staff?  
\_\_\_\_\_

What did you like least? \_\_\_\_\_

Do you want the very best dentistry we can provide for you, or want to patch it and get by?  
\_\_\_\_\_

Should we see something that needs to be done that your insurance does not cover, what would you like to do about it?  
\_\_\_\_\_

**Patient's signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Reviewed by Doctor** \_\_\_\_\_ **Date** \_\_\_\_\_

**Significant Findings**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_