Dental History Form – Scripps Center for Dental Care

Patient Name:_____Date of Birth:_____

Date of Last Dental Visit?_____/_____/_____

Reason for the Visit?_____

Date of Last Dental Radiographs/X-Rays? _____/_____/_____

Former
Dentist:_____Phone:_____

If you left your previous dentist, what was the
reason?_____

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

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

At Home Oral Hygiene Care

How often do you brush your
teeth?_____

How often do you
floss?_____

Do you use mouthwash? Yes/No

If YES, which kind:_____

Do you use any other dental home care products? Yes/No

If YES, which kind:_____

Circle Appropriate Answer: (Leave blank if you do not understand the questions)

1. Are you currently experiencing dental pain or discomfort? Yes/No

   If Yes, explain:

   _____

2. Do your gums bleed? Yes/No

If Yes, explain:

_____

3. Are your teeth loose? Yes/No

   If Yes, explain:

   _____

4. Do you wear dentures or partials? Yes/No

   If Yes, explain:

   _____

5. Have you ever been told you have gum disease? Yes/No
   If Yes, explain:

   _____

6. Are your teeth sensitive to hot, cold, sweets, or pressure? Yes/No
   If Yes, explain:

   _____

7. Have you ever had any clicking, popping, or discomfort in the jaw? Yes/No
   If Yes, explain:

   _____

8. Do you brux or grind your teeth? Yes/No
   If Yes, explain:

   _____

9. Do you wear an occlusal guard? Yes/No

10. Have you ever had orthodontic treatment (braces) before? Yes/No
    If Yes, explain:

    _____

11. Do you have dry mouth? Yes/No
    If Yes, explain:

    _____

12. Does food or floss catch between your teeth? Yes/No
    If Yes, explain:

    _____

13. Have you had any problems or experienced an upsetting dental experience associated with previous dental care? Yes/No
    If Yes, explain:
    _____
14. Are you fearful of dentistry or have anxiety associated with dental treatment? Yes/No
    If Yes, explain:
    _____
15. Have you ever been pre-medicated for dental treatment? Yes/No
    If Yes, explain:
    _____
16. Have you ever had a reaction to anesthetic used with your dental treatment? Yes/No
    If Yes, explain:
    _____
17. Are you happy with your smile? Yes/No
    If Yes, explain:
    _____
18. What would you change about the present condition of your mouth?
    _____
19. Is there anything else you would like us to know about your dental health or dental history? Yes/No
    If Yes, explain:
    _____

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful dental history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction.

Signature of Patient (Parent or Guardian) **Date**

_____

Signature of Dentist **Date**

_____