Patient Name: _____

Patient DOB: _____

New Patient Dental History Form

edinadentalcare
COMPREHENSIVE AND AESTHETIC DENTAL CARE

Previous Dentist/Dental Office: _____

Previous Dentist's City/State: _____

Previous Dentist's Phone Number: _____

Date of Last Dental Visit: _____

Date of Last Radiographs: _____

Are you satisfied with your past dentistry? ☐ Yes ☐ No

If no, please explain:

_____

Did your previous dentist advise any treatment that you have not yet done? ☐ Yes ☐ No

If yes, please explain:

_____

Has fear or discomfort kept you from regular dental visits? ☐ Yes ☐ No

If yes, please share:

_____

Have you ever had:

- ☐ Teeth removed
- ☐ Orthodontic treatment
- ☐ Periodontal treatment
- ☐ TMD treatment
- ☐ Bite adjustment
- ☐ Root canal treatment
- ☐ Nightguard or bitesplint
- ☐ Serious injury to mouth or head
- ☐ Frequent cold sores, blisters or any other lesions
- ☐ None of the above

Have you experienced:

- ☐ Clicking, popping or locking of the jaw
- ☐ Jaw pain (joint, ear, side of face)
- ☐ Difficulty in opening or closing your mouth
- ☐ Tired jaw, especially in the morning
- ☐ Tired jaw, especially in the morning
- ☐ Clenching or grinding your teeth while awake or asleep
- ☐ Sensitive teeth to cold, hot, sweets, biting, or chewing
- ☐ None of the above

What is the goal you have for your teeth? _____

What is the goal you have for your dental health? _____

How often do you brush? _____ How often do you floss? _____

Do you use any other dental aids? _____

Is there anything else we should be aware of regarding your dental health or this appointment?

_____

_____