

Dr. Killian Patient Dental History (Copy)

Patient Name:

Birth Date:

Date Created:

Check the Appropriate

Purpose of initial visit? Comment

Are you aware of a problem? Yes No If yes

How long since your last dental visit?

What was done at that time? Comment

Previous dentist's name Comment

When was the last time your teeth were cleaned?

Have you made regular visits? Yes No

Were dental x-rays taken? Yes No If yes

Have you lost any teeth or have any teeth been removed? Yes No If yes

Have they been replaced? How? Yes No If yes

Are you unhappy with the replacement? Yes No If yes

Would you like to know about permanent replacements? Yes No If yes

Have you ever had any problems/complications with previous dental treatment? Yes No If yes

Do you clench or grind your teeth? Yes No If yes

Does your jaw click or pop? Yes No If yes

Have you experienced any pain or soreness in the muscles around your face/ear? Yes No If yes

Do you have frequent head, neck or shoulder aches? Yes No If yes

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

Are any of your teeth sensitive to: Hot, Cold, Sweets, Pressure? Yes No If yes

Do your gums bleed or hurt? Yes No If yes

Do you experience dry mouth? Yes No If yes

How often do you brush your teeth and when? Comment

Do you use dental floss? How Often? Yes No If yes

Are any of your teeth loose, tipped, shifted or chipped? Yes No If yes

Are you unhappy with the appearance of your teeth? Yes No If yes

Do you feel your breath is offensive at times? Yes No If yes

Have you had any gum treatment or surgery? Yes No If yes

Have you had any unpleasant dental experiences? Yes No If yes

Have you had any orthodontic work? Yes No If yes

I CERTIFY THAT THE INFORMATION IS COMPLETE AND ACCURATE

Signature of Patient, Parent or Guardian:

X

Date: _____

AUTHORIZED BY

Signature of DENTIST:

X

Date: _____