



# Encino Dental Group

Dr. Mamaliger

## Dental History Form

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Date of last dental visit? \_\_\_\_/\_\_\_\_/\_\_\_\_ Reason for the visit? \_\_\_\_\_

Date of last dental X-rays? \_\_\_\_/\_\_\_\_/\_\_\_\_

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

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 question)

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: \_\_\_\_\_



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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



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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 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 premedicated 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 history? YES / NO  
If YES, explain: \_\_\_\_\_