DENTAL HISTORY

Madsen & Hirsch
Dental Care

Patient Name: _____ DOB: ____/____/_____

Former Dentist: _____ Address: _____
When was your last dental visit?: _____ What was done: _____
Were X-Rays taken: ❑Yes ❑No
Has any dental treatment been recommended that you have not completed? ❑Yes ❑No
Describe: _____

How do you feel about dental treatment?: ❑Relaxed ❑Uneasy ❑Anxious ❑Very Anxious ❑Major Phobia
Do any of the following prevent you from visiting the dentist regularly? ❑Money ❑Time ❑Fear
Reason for your visit: _____
Are you aware of any dental problems?: ❑Yes ❑No Describe: _____
Are you experiencing any dental pain or discomfort?: ❑Yes ❑No Describe:_____
Please Rate the condition of your mouth: ❑Good ❑Fair ❑Poor
Are your teeth sensitive to: ❑Nothing ❑Sweets ❑Cold ❑Heat ❑Pressure

ARE YOU CONCERNED WITH:

Yes	No	
❑	❑	Earaches or neck pains
❑	❑	Clicking, popping, or discomfort in the jaw
❑	❑	Clenching or Grinding teeth
❑	❑	Headaches
❑	❑	Sores or Ulcers in the mouth
❑	❑	Mouth Breathing
❑	❑	Snoring or Sleep apnea
❑	❑	Missing Teeth
❑	❑	Offensive/bad breath
❑	❑	Toothaches
❑	❑	Loose teeth
❑	❑	Chipped or Broken teeth
❑	❑	Swollen Glands
❑	❑	Misc: _____

HOW OFTEN DO YOU:

Brush: _____ Floss: _____
Clean Tongue:_____ Mouthwash: _____

Yes	No	
❑	❑	Do you use an electric toothbrush?
❑	❑	Bleeding when brushing?
❑	❑	Bleeding when flossing?

APPEARANCE OF YOUR SMILE:

Yes	No	
❑	❑	Would you like whiter teeth?
❑	❑	Would you like straighter teeth?
❑	❑	Are you interested in Botox?
❑	❑	Are you interested in dermal fillers?
❑	❑	Are you interested in custom mouth guards?

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Yes	No	
❑	❑	Periodontal (gum) treatment? *If Yes, what*?: _____
❑	❑	Jaw Joint symptom treatment? *If yes, what*?: _____
❑	❑	Orthodontics (braces) treatment? *If yes, what kind?:*_____
❑	❑	Problems associated with previous dental treatment? *If yes, what*?: _____

Patient Signature: _____ Date: _____

To the best of my knowledge, the information given on this form is accurate. I understand that providing incorrect information can be dangerous to my health. I will not hold my dentist, or any member of his staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. It is my responsibility to inform the dental office of any changes in medical status.