

Nicollet Mall Dental Arts
Eglesoft Dental History

Patient Name:

Birth Date:

Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Purpose of initial visit	<input type="text"/>	Comment	<input type="text"/>
Are you aware of a problem?	<input type="text"/>	Comment	<input type="text"/>
How long since your last dental visit?	<input type="text"/>	Comment	<input type="text"/>
What was done at that time?	<input type="text"/>	Comment	<input type="text"/>
Previous dentist's name	<input type="text"/>	Comment	<input type="text"/>
When was the last time your teeth were cleaned?	<input type="text"/>	Comment	<input type="text"/>
Have you made regular visits and how often?	<input type="text"/>	Comment	<input type="text"/>
Do you clench or grind your teeth?	<input type="text"/>	Comment	<input type="text"/>
Does your jaw click or pop?	<input type="text"/>	Comment	<input type="text"/>
Have you experienced any pain or soreness in the muscles of your face or around your ear?	<input type="text"/>	Comment	<input type="text"/>
Do you have frequent headaches, neckaches or shoulder aches?	<input type="text"/>	Comment	<input type="text"/>
Does food get caught in your teeth?	<input type="text"/>	Comment	<input type="text"/>
Are any of your teeth sensitive to: Hot? Cold? Sweets? Pressure?	<input type="text"/>	Comment	<input type="text"/>
Do your gums bleed or hurt? If so, when?	<input type="text"/>	Comment	<input type="text"/>
Do you experience dry mouth?	<input type="text"/>	Comment	<input type="text"/>
How often do you brush your teeth?	<input type="text"/>	Comment	<input type="text"/>
How often do you floss your teeth?	<input type="text"/>	Comment	<input type="text"/>
Are any of your teeth loose, tipped, shifted or chipped?	<input type="text"/>	Comment	<input type="text"/>
Have you ever had gum treatment or surgery? If so, when?	<input type="text"/>	Comment	<input type="text"/>
Have you had any orthodontic work (braces)?	<input type="text"/>	Comment	<input type="text"/>
Are you unhappy with the appearance of your teeth?	<input type="text"/>	Comment	<input type="text"/>
Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike?	<input type="text"/>	Comment	<input type="text"/>

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date: _____