Kuras Dental Health Associates

Dental History Form

Patient Name: ________________________

Date: ________________________

1. Purpose of initial visit? ____
2. Are you aware of any problems? ____
3. How long has it been since your last dental visit? ________________________________
4. What was done at that visit? ____

   ____
5. What was your previous dentists name? ____

   Address? ____

   ____
6. When was the last time your teeth were cleaned? _________________________________

Please circle the correct answer, if you do not know the correct answer please write "UNKNOWN" on the line provided after the question.

1. Do you regularly visit the dentist?………………………………………………… YES NO

   How often? ________________________________
2. Have you had dental x-rays taken within the last year?……………………… YES NO
3. Have you lost any teeth or had any removed?……………………………….. YES NO

   Why? ______________________________________
4. Have they been replaced? ________________________

   How?
   - ❑ Fixed Bridge Age: _______
   - ❑ Removable Partial Age: _______
   - ❑ Denture Age: _______
   - ❑ Implant Age: _______
5. Are you happy with the replacement?……………………………………….. YES NO

   If no, explain _______________________________

   ____
6. Would you like to know about permanent replacements?…………………… YES NO
7. Have you ever had previous problems/complications with dental treatment? YES NO

   If yes, explain _______________________________

   ____
8. Do you clench or grind your teeth?…………………………………………... YES NO
9. Does your jaw click or pop?…………………………………………………. YES NO
10. Have you experienced any pain or soreness in the muscles around your face or ear?………………………………………………………………………… YES NO
11. Do you have frequent neck aches, shoulder aches, or headaches?…………... YES NO
12. Does food get caught in your teeth?………………………………………… YES NO
13. Are any of your teeth sensitive to:
    - ☐ Hot?
    - ☐ Cold?
    - ☐ Sweets?
    - ☐ Pressure?

14. Do your gums bleed or hurt?…………………………………………………… YES NO
    If yes, when ____
15. Have you ever had gum treatment or surgery? ……………………………… YES NO
    What? ____
    Where? ____
    When? ____
16. How often do you brush your teeth in a day? ______________________
17. Do you use dental floss?…………………………………………………... YES NO
    If yes, how often? ____
18. Are any of your teeth loose, tipped, shifted, or chipped?……………………. YES NO
19. Are you unhappy with the appearance of your teeth?……………………….. YES NO
20. How do you feel about your teeth in general?______________________
    ____
21. Do you feel that your breath is offensive at times?………………………….. YES NO
22. Have you had any orthodontic work?………………………………………... YES NO
23. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike? ______________________________
    ____
24. Do you have any questions or concerns?…………………………………….. YES NO

I certify that the above information is complete and accurate.

Patient Signature: ____

Parent / Guardian Signature: ____________________________________

Dentist Signature: ____