ALICIA L. DWYER D.D.S. P.A.

PATIENT'S NAME _____

LAST FIRST DATE OF BIRTH

1	Purpose of Initial Visit			Comments:
2	Are you aware of any problems?	YES	NO	
3	How long has it been since your last dental visit?			
4	What was done at the time?			
5	Previous Dentist Name? Address			
6	When was the last time your teeth were cleaned?			
	In the following, circle the appropriate answer. If you don't know the answer, please write "Don't know" after the question.			
7	Have you made regular dental visits? How often?	YES	NO	
8	Were dental x-rays taken?	YES	NO	
9	Have you lost any teeth or have they been removed?	YES	NO	
10	Have they been replaced? If yes, answer questions 11 and 12	YES	NO	
11	How have they been replaced? a. Fixed Bridge? Age_____ b. Removable Partial? Age_____ c. Denture? Age_____	YES	NO	
12	Are you happy with the replacement?	YES	NO	
13	Would you like to know about permanent replacement?	YES	NO	
14	Have you ever had any problems or complications with previous dental treatment? If yes, please explain.	YES	NO	
15	Do you clinch or grind your teeth?	YES	NO	
16	Does your jaw click or pop?	YES	NO	
17	Have you experienced any pain or soreness in the muscles of your face or around your ear?	YES	NO	
18	Do you have frequent headaches, neck aches, or shoulder aches?	YES	NO	
19	Does food get caught in your teeth?	YES	NO	
20	Are your teeth sensitive to: Hot? Cold? Sweets? Pressure?	YES	NO	
21	Do your gums bleed or hurt?	YES	NO	
22	How often do you brush your teeth? When?			
23	Do you use dental floss? How often?	YES	NO	
24	Are any of your teeth loose, tipped, shifted, or chipped?	YES	NO	
25	Are you unhappy with the appearance of your teeth?	YES	NO	
26	How do you feel about your teeth in general?			
27	Do you feel your breath is offensive at times?	YES	NO	
28	Have you ever had gum treatment or surgery? When? What? Where?	YES	NO	
29	Have you ever had orthodontic treatment?	YES	NO	
30	Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike?	YES	NO	
31	Do you have any questions or concerns?	YES	NO	

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACURATE.

Patient's/Guardian's Signature_____ Date_____

Dentist's Signature_____ Date_____

DENTAL HISTORY