DENTAL HISTORY

1. What is your reason for visiting our office?

____

2. How long have you had this problem, if applicable?

____

3. Have you been under regular care by a dentist? ○ Yes ○ No

____

4. When was your last dental visit?

____

5. Have you ever had local anaesthetic (freezing)? ○ Yes ○ No

____

6. If so, were there any complications? ○ Yes ○ No

____

7. Have you ever had any teeth extracted (pulled)? ○ Yes ○ No

____

8. If so, were there any complications? ○ Yes ○ No

____

9. Have you had any other dental work besides fillings? (eg. gum surgery, root canal, orthodontics, other)
Please specify____

10. Are you happy with the appearance of your teeth? ○ Yes ○ No
If not, why?____

11. Do you consider yourself to be an anxious dental patient ○ Yes ○ No

____

12. On a scale of 1 (not at all) to 10 (very anxious) please rate your anxiety?

1 2 3 4 5 6 7 8 9 10

13. What makes you most anxious in the dental office?

____

To the best of my knowledge, my medical history and dental history are correct:

____ _________________________

PATIENT/PARENT/GUARDIAN SIGNATURE: DATE

____ _________________________

DENTIST SIGNATURE: DATE

MEDICAL ALERT AND NOTES: