The Atlanta Center for Restorative Dentistry

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Dental History

Name:			
Date of Birth:		**Gender:**	
Purpose of Initial Visit:			
Are you aware of a problem? If so, please describe.			
Date of last dental visit			
What was done at that time?			
Name, address and phone of your previous dentist.			
Date of last cleaning			
Have you made regular visits?		◯ **Yes**	◯ **No**
How often?			
Were dental x-rays taken?		◯ **Yes**	◯ **No**
Have you lost or had any teeth removed?		◯ **Yes**	◯ **No**
Why?			
If the teeth have been replaced, how were they replaced?			

☐ **Fixed Bridge**	**Age**		☐ **Removable Bridge**	**Age**	
☐ **Denture**	**Age**		☐ **Implant**	**Age**	

Are you unhappy with the replacement?		◯ **Yes**	◯ **No**
If so, why?			
Would you like to know about permanent replacements?		◯ **Yes**	◯ **No**
Have you ever had any problems or complications with previous dental treatment?		◯ **Yes**	◯ **No**
If yes, please explain.			

Comments

Question	Yes	No
Do you clench or grind your teeth?	◯ Yes	◯ No
Does your jaw click or pop?	◯ Yes	◯ No
Have you experienced any pain or soreness in the muscles of your face or around your ear?	◯ Yes	◯ No
Do you have frequent headaches, neck aches, or shoulder aches?	◯ Yes	◯ No
Does food get caught in your teeth?	◯ Yes	◯ No
Are any of your teeth sensitive to:	☐ Hot? ☐ Sweet?	☐ Cold? ☐ Pressure?
Do your gums bleed or hurt?	◯ Yes	◯ No
When?		
Do you experience dry mouth?	◯ Yes	◯ No
How often do you brush your teeth?		
When?		
Do you use dental floss?	◯ Yes	◯ No
How often?		
Are any of your teeth loose, tipped or shifted?	◯ Yes	◯ No
Are you unhappy with the appearance of your teeth?	◯ Yes	◯ No
How do you feel about your teeth in general?		
Do you feel your breath is offensive at times?	◯ Yes	◯ No
Have you ever had gum treatment or surgery?	◯ Yes	◯ No
What?		
Where?		
When?		
Have you had any orthodontic work?	◯ Yes	◯ No
Describe any unpleasant dental experiences or is there anything about dentistry that you strongly dislike?		
Do you have any questions or concerns?	◯ Yes	◯ No

Comments

I certify that the above information is complete and accurate.

Patient Signature:		Date:	
Dentist Signature:		Date:	