DeJesus Dental Group
COSMETIC, FAMILY & IMPLANT DENTISTRY

Patients Name _____ Date of Birth_____

COMMENTS

1. Purpose of initial visit?_____
2. Are you aware of a problem?_____
3. How long since your last visit?_____
4. What was done at the time?_____
5. Previous dentist's name_____
    Address_____ Tel._____
6. When was the last time your teeth were cleaned?_____
    PLEAE CHECK THE APPROPRIATE ANSWER
7. Have you made regular visits?.. □ YES □ NO
    How often?_____
8. Were dental x-rays taken?…………………………………….. □ YES □ NO
9. Have you lost any teeth or have any teeth been removed?............. □ YES □ NO
    Why?_____
10. Have they been replaced? …………………………………….. □ YES □ NO
11. How have they been replaced?
    a. Fixed Bridge_____Age_____
    b. Removable Bridge_____ Age_____
    c. Denture_____Age_____
    d. Implant_____Age_____
12. Are you unhappy with the replacement?.. □ YES □ NO
    Why?_____
13. Would you like to know about permanent replacements?................ □ YES □ NO
14. Have you ever had any problems with previous dental treatment? □ YES □ NO
15. Do you clench or grind your teeth?... □ YES □ NO
16. Does your jaw click or pop?.. □ YES □ NO
17. Have you experienced pain/soreness in 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: (check all that apply) □ Hot   □ Cold □ Sweets   □ Pressure
21. Do your gums bleed or hurt?... □ YES □ NO
22. Do you experience dry mouth?.. □ YES □ NO
23. How often do you brush your teeth?_____ When_____
24. Do you use dental floss?.. □ YES □ NO
25. Are any of your teeth loose, tipped, shifted or chipped?.................. □ YES □ NO
26. Are you unhappy with the appearance of your teeth?...................... □ YES □ NO
27. How do you feel about your teeth in general?................................. □ YES □ NO
28. Do you feel your breath is offensive at times? …………………… □ YES □ NO
29. Have you ever had gum treatment or surgery? …………………… □ YES □ NO
30. Have you ever had orthodontic work?... □ YES □ NO
31. Have you had any unpleasant dental experiences or is there anything about dentistry that
    you strongly dislike?_____
32. Do you have any questions or concerns?.. □ YES □ NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S/GUARDIAN'S SIGNATURE_____DATE_____

DENTIST'S SIGNATURE_____DATE_____

DENTAL HISTORY