DENTAL HISTORY

Former dentist _____ Phone # _____

What services are you interested in today? _____

Are you in pain? ☐ YES ☐ NO Do you sometimes have sores in or around your mouth? ☐ YES ☐ NO

Do you have dental anxiety? ☐ YES ☐ NO How would you rate your daily oral hygiene regimen? _____

Approximate date of last dental x-rays _____ Have you ever been treated for a TMJ disorder? ☐ YES ☐ NO

Approximate date of last cleaning _____ How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction to a dental procedure? ☐ YES ☐ NO

Do any children (6 mo. - 16 yrs) in your household regularly consume well-water or bottled water? ☐ YES ☐ NO

Have you ever been treated for periodontal disease? ☐ YES ☐ NO

Are you concerned about bad breath? ☐ YES ☐ NO

Other pertinent information about your dental health or previous treatment. _____

_____

_____

To the best of my knowledge, all the answers on this form are true and correct. If I ever have any changes in my health, or if my medicines change, I will inform Walker Dentistry at my next appointment.

Signature (Patient, Parent or Guardian) X _____ Date _____

MEDICAL UPDATES:

DATE: _____ DATE: _____ DATE: _____

DATE: _____ DATE: _____ DATE: _____