Dental History Form

Welcome to Keyser Dentistry! To provide you with the best possible care, please complete this dental history form. All information is completely confidential.

Patient Name:_____

Medical Alert:_____

What is the reason for your visit today?_____

Date of last dental visit?_____**Last cleaning?**_____**Last full mouth x-rays:**_____

What was done at your last dental visit?_____

Previous Dentist's Name:_____
Address:_____
Phone:_____

How often do you have dental examinations?_____

What other dental aids do you use?_____

Do you have any dental problems now? If so, please describe:_____
_____

Any any of your teeth sensitive to? (Please check all that apply).

☐ Hot or cold?
☐ Sweets?
☐ Biting or Chewing?
☐ Have you noticed bad tastes?
☐ Do you frequently get cold sores, blisters, or any other oral lesions?

Do your gums bleed or hurt? (Please check all that apply).

☐ Have your parents experienced gum disease or tooth loss?
☐ Have you noticed loose teeth or a change in your binte?
☐ Does food tend to get caught between your teeth?