HIGHLAND
DENTAL

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Dental History

Patient Name: _____ Date: _____

Are you the patient? ☐ YES ☐ NO Is the patient a minor? ☐ YES ☐ NO

If you are the patient completing form, complete below questionnaire.

If you are completing this form for a minor child, please complete the questionnaire associated with a minor child addressed below.

Reason For Visit: _____

Date Of Last Dental Visit: _____

Date Of Last Dental X-Rays: _____

How Often Do You Floss: _____

How Often Do You Brush: _____

Check All That Apply:

- ☐ Bad Breath
- ☐ Bleeding, Red, Swollen Gums
- ☐ Broken/Loose teeth or fillings
- ☐ Clicking or popping jaw
- ☐ Grinding teeth
- ☐ Pain around ear/side of face
- ☐ Sores/Blisters in mouth

List Any Other Dental Concerns/Pain: _____

PLEASE COMPLETE IF PATIENT IS A MINOR CHILD:

Provider Name: _____

Provider Phone Number: _____

Does your child have any of the following?
Check All That Apply:

- ☐ Cavities / Decay
- ☐ Lip Sucking / Biting
- ☐ Speech Problems
- ☐ Nail Biting
- ☐ Grinding Teeth
- ☐ Pacifier / Thumb or Finger Sucking
- ☐ Mouth Breathing
- ☐ Tongue Thrust
- ☐ Nursing / Bottle Habits
- ☐ Jaw Problems

Has the patient ever had orthodontic treatment? (Braces) ☐ YES ☐ NO

Has the patient ever had any pain/tenderness in their jaw joint (TMJ/TMD)? ☐ YES ☐ NO

What did you like the most about your previous dental office?

_____

_____

What did you like the least about your previous dental office?

_____

_____

Is the patient interested in whitening their smile? ☐ YES ☐ NO

Is the patient happy with their smile? ☐ YES ☐ NO

If not, what would you change? _____

Signature: _____ **Date:** _____