Gateway Dental Group

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Dental History

Patient Name: ______________________ ______________________ ____ ______________________

Last | First | MI | Preferred Name

What is the reason for your visit today?

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What concerns do you have about going to the dentist?

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Who was your previous dentist, and how long were you a patient?

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When was your most recent dental exam?

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Are you satisfied with the appearance of your teeth? ◯ Yes ◯ No

If you are not satisfied with the appearance of your teeth, please explain:

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Please select the dental conditions or treatments which you have had in the past:

- ☐ Dental infection
- ☐ Oral cancer
- ☐ Filling
- ☐ Bridge
- ☐ Other permanent (adult) teeth extracted
- ☐ Orthodontics (braces)
- ☐ Complete denture
- ☐ Periodontal treatment (deep cleaning, scaling & root planing)
- ☐ Porcelain veneers
- ☐ Tooth whitening (bleaching)
- ☐ Dental or facial trauma/injury
- ☐ Cavity
- ☐ Crown (cap)
- ☐ Wisdom teeth extracted
- ☐ Root canal
- ☐ Partial denture
- ☐ Periodontal disease (gum disease, pyorrhea)
- ☐ Periodontal surgery (gum surgery)
- ☐ Dental implant
- ☐ Elective cosmetic dental procedure

Select any conditions which have applied to you:

- [ ] Problems getting numb
- [ ] Bad reaction to anesthetic
- [ ] Problems chewing gum
- [ ] Problems chewing bagels
- [ ] Sleep problems/disorders
- [ ] Jaw problems (TMJ)
- [ ] Jaw click or pop
- [ ] Trouble opening mouth widely
- [ ] Tension headaches
- [ ] Clench or grind teeth
- [ ] Family history of periodontal (gum) disease
- [ ] Bleeding gums when brushing or flossing
- [ ] Areas where you avoid brushing or flossing due to discomfort
- [ ] Temperature sensitivity
- [ ] Dry mouth
- [ ] Difficulty swallowing
- [ ] Burning sensation in your mouth
- [ ] Unpleasant taste in your mouth
- [ ] Bad breath

Response Date: ____________