Download this file and open it in a compatible PDF reader. Enter your answers, save a copy, then upload it through the enabled return option or bring it to your appointment. Saving the PDF does not send it to the clinic. A completed copy contains personal health information: keep it on a trusted device. If your PDF app can't save, print the form and fill it in by hand.
Dates: YYYY-MM-DD (for example 2026-10-01). Leave anything you'd rather discuss in person; a blank is not a "No".

History

What has prompted your visit to our office today? (up to 1000 characters; use the continuation page for more)

Name of your previous dentist

City

When was your last visit to a dental office?

Last cleaning?

Last x-ray?

How often did you see your dentist?

Are you having any dental troubles right now? ○ Yes ○ No

What troubles are you having? (up to 1000 characters; use the continuation page for more)

Would you like to retain your healthy natural teeth as long as possible? ○ Yes ○ No

Do any of the following cause you discomfort?

☐ Hot ☐ Cold ☐ Sweet ☐ Chewing

Have you had periodontal (gums) treatment? ○ Yes ○ No

Do your gums bleed? ○ Yes ○ No

Do your gums ever feel tender/swollen? ○ Yes ○ No

Do you have any loose teeth? ○ Yes ○ No

Are you aware of bad breath/taste in your mouth? ○ Yes ○ No

Do you smoke? ○ Yes ○ No

How often do you brush your teeth?

Floss?

Water jet?

Other

Do you clench or grind your teeth? ○ Yes ○ No

Do your jaws ever feel tired or ache? ○ Yes ○ No

Does your jaw click or pop? ○ Yes ○ No

Can you chew on both sides of your mouth? ○ Yes ○ No

Comfortably? ○ Yes ○ No

Are your teeth worn down? ○ Yes ○ No

Do you have frequent headaches? ○ Yes ○ No

Do you have frequent earaches? ○ Yes ○ No

Have you ever had orthodontic treatment (braces)? ○ Yes ○ No

If yes, when?

Do you have missing teeth? ○ Yes ○ No

Have they been replaced? ○ Yes ○ No

If so, how?

☐ Fixed bridge ☐ Removable partial ☐ Full denture ☐ Dental implant

Are you happy with the replacement? ○ Yes ○ No

Please describe: (up to 1000 characters; use the continuation page for more)

How do you feel about the appearance of your smile? (up to 1000 characters; use the continuation page for more)

What cosmetic dentistry have you had done?

Are you happy with it?

○ Yes ○ No ○ Doesn't apply

Please explain (up to 1000 characters; use the continuation page for more)

Have you ever been sedated for a dental appointment? ○ Yes ○ No

Have you ever had an unpleasant dental visit? ○ Yes ○ No

If yes, please comment (up to 1000 characters; use the continuation page for more)

Please add anything you feel is important (up to 2000 characters; use the continuation page for more)

Continuation page

Use this page if any answer needs more room. Write the question it continues.