James D. Dickinson, D.D.S., Inc.

11777 Bernardo Plaza Ct., Suite 102
San Diego, CA 92128
(858) 487-7766

Patient's Name _____ _____ _____ _____
Last First Initial Date of Birth

COMMENTS

1. Purpose of initial visit _____
2. Are you aware of a problem? _____
3. How long since your last dental visit? _____
4. What was done at that time _____
5. Previous dentist's name _____
   Address _____
   Telephone _____
6. When was the last time your teeth were cleaned? _____

	YES	NO
7. Have you made regular visits?	☐	☐
8. Were dental x-rays taken?	☐	☐
9. Have you lost any teeth or have any teeth been removed?	☐	☐
Why? _____		
10. Have they been replaced?	☐	☐

11. How have they been replaced?
    a. Fixed bridge _____ Age _____
    b. Removable bridge _____ Age _____
    c. Denture _____ Age _____
    d. Implant _____ Age _____

12. Are you unhappy with the replacement?	☐	☐
If yes, explain _____		
13. Would you like to know about permanent replacements?	☐	☐
14. Have you ever had any problems or complications with previous dental treatment?	☐	☐
If yes, explain _____		
15. Do you clench or grind your teeth?	☐	☐
16. Does your jaw click or pop?	☐	☐
17. Have you experienced any pain or soreness in the muscles of your face or around your ear?	☐	☐

Dental History

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	YES	NO	COMMENTS
18. Do you have frequent headaches, neckaches or shoulder aches?.....	☐	☐	
19. Does food get caught in your teeth?.....	☐	☐	
20. Are any of your teeth sensitive to: ☐ Hot? ☐ Cold? ☐ Sweets? ☐ Pressure?			
21. Do your gums bleed or hurt?.....	☐	☐	
22. Do you experience dry mouth?.....	☐	☐	
23. How often do you brush your teeth?_____ When?_____			
24. Do you use dental floss?..... How often?_____	☐	☐	
25. Are any of your teeth loose, tipped, shifted or chipped?.....	☐	☐	
26. Are you unhappy with the appearance of your teeth?.....	☐	☐	
27. How do you feel about your teeth in general?_____			
28. Do you feel your breath is offensive at times?.....	☐	☐	
29. Have you ever had gum treatment or surgery?..... What?_____ Where?_____ When?_____	☐	☐	
30. Have you had any orthodontic work?..... If yes, explain_____	☐	☐	
31. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike?..... If yes, explain_____	☐	☐	
32. Do you have any questions or concerns?.....	☐	☐	

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S/GAURDIANS SIGNATURE_____ Date_____

DENTIST'S SIGNATURE_____ Date_____

Dental History