Chapel Hill Dental Group

Dental History

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/contact info:
   _____
   _____
   _____
6. When was the last time your teeth were cleaned? _____
7. Were dental x-rays done at that time? _____
8. Have you ever had any problems or complications with previous dental treatment?
   YES NO if yes, explain:
   _____
   _____
9. Do you have frequent headaches, neck aches or shoulder aches? YES NO
10. Does food get caught anywhere in your teeth? YES NO
11. Do your gums bleed or hurt? YES NO If yes, when? _____
12. What is your normal hygiene routine (what do you do and when/how often)?
    _____
    _____
13. Do you feel your breath is offensive at times? YES NO
14. Have you ever had gum surgery or treatment? YES NO
    If yes, What? _____
    Where/When?_____
15. Have you had any orthodontic work? YES NO
    If yes, explain/detail:_____
16. If you have had any unpleasant dental experiences or there anything about dentistry that you strongly dislike, please tell us about it.
    _____
    _____
17. If you have any questions or concerns, please feel free to list them on the back of this sheet or let us know during your appointment.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

Patient/Guardian Signature: _____ Date: _____

Dentist Signature: _____ Date: