



HAYDEN CHARLES DENTAL CARE

DENTAL HISTORY QUESTIONNAIRE

Name : _____

Date of Birth (DD/MM/YYYY) : _____

Address : _____

Phone : _____

Email ID : _____

Occupation : _____

Referred by : _____

In case of Emergency, we should notify :

Emergency Contact Name : _____

Relationship : _____

Phone : _____

Name of Family Doctor : _____

Phone or Address : _____

Name of Medical Specialist : _____

Area of Speciality : _____

Phone or Address : _____

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private and is protected by doctor – patient confidentiality. The dentist will review the questions and explain anything that you do not understand. Please fill in the entire form.

1) What is the reason for your visit today? Are you currently experiencing any dental problems?

If yes, please explain : _____

2) Have you been seeing a dentist regularly? If not, why not?

Yes No

If not, why not? : _____

3) Are you nervous during dental visits?

Yes No Not Sure/Maybe

4) Have you had a bad experience or complications during dental treatment?

Yes No Not Sure/Maybe

5) When was your last dental visit? What was done at that appointment?

Please Explain : _____

6) When did you last have dental X-rays?

Please Explain : _____



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7) Have you ever seen a dental specialist? Yes No Not Sure/Maybe

8) How often do you brush your teeth? How often do you floss? Do your gums bleed when you brush or floss?

Please Explain : _____

9) Have you been told to take antibiotics before a dental appointment? Yes No Not Sure/Maybe

10) Do you feel that you have bad breath? Yes No Not Sure/Maybe

11) Are you happy with the appearance of your teeth? Yes No Not Sure/Maybe

12) Do you have any problems with your jaw (clicking, limited movement, pain)?

Yes No Not Sure/Maybe

13) Have you ever had an injury to the teeth or jaws or been involved in a motor vehicle accident?

Yes No Not Sure/Maybe

To the best of knowledge, the above information is correct :

Patient/Parent/Guardian Signature : _____ *Date :* _____

Dentist Signature : _____ *Date :* _____

DENTIST'S NOTES :