Johnson DENTAL | HEALTHY SMILES. EXCEPTIONAL CARE. EVERY DAY.

Adult Dental History

Patient Name: _____

Date of birth: _____

Dental History

What is the reason for today's visit?_____

Previous Dentist:_____ Telephone #:_____

Date of last exam:_____ Date of last dental x-rays:_____

How often do you brush?_____ How often do you floss?_____

Please provide details about conditions that you check below:_____

- ☐ Bad Breath
- ☐ Food trapping between teeth
- ☐ Bleeding gums
- ☐ Periodontal treatment
- ☐ Loose teeth or broken fillings
- ☐ Sensitivity to sweets
- ☐ Sensitivity to temperatures (hot/cold)
- ☐ Sensitivity or pain when biting/chewing
- ☐ Swelling in the mouth/neck area
- ☐ Sores or growths in your mouth
- ☐ Previous injury to mouth or jaw
- ☐ Previous surgery in mouth
- ☐ Grinding/clenching habit
- ☐ Clicking or popping TMJ/joint
- ☐ Pain in TMJ/muscle tension in face or joint area

Have you ever had an unusual reaction to a dental anesthetic? ☐ Yes ☐ No

Have your past dental experiences been satisfactory? ☐ Yes ☐ No

Do you have any concerns/fears about dental treatment? ☐ Yes ☐ No

Have you had nitrous oxide for your dental treatment in the past? ☐ Yes ☐ No

Explain any yes answers from above:_____

Smile evaluation

Do you have spaces between your teeth that you would like closed? ☐ Yes ☐ No
Explain:_____

Do you have missing teeth that you would like to replace? ☐ Yes ☐ No
Explain:_____

Do you have black or silver fillings that you would like to replace? ☐ Yes ☐ No
Explain:_____

Do you like the way your teeth look? ☐ Yes ☐ No
Explain:_____

Are you happy with the color of your teeth? ☐ Yes ☐ No
Explain:_____

Would you like your teeth to be straighter? ☐ Yes ☐ No
Explain:_____

Would you like your teeth to be whiter? ☐ Yes ☐ No
Explain:_____

Do you like the shape of your teeth? ☐ Yes ☐ No
Explain:_____

If you could change anything about your smile, what would you change?
Explain:_____