Family & Cosmetic Dentistry
Raymond Ferri, D.D.S., & Patrick Lawrence, D.D.S., P.A.

Adult Dental History Form

Patient Personal Information

Name:	**Age:**
DOB:	**E-mail:**

Dental History

Previous Dentist:	
Address:	
Date of most recent dental exam:	**Date of most recent x-rays:**
I routinely see my dentist every: ❑ 3 mo. ❑ 4 mo. ❑ 6 mo. ❑ 12 mo. ❑ Not Routinely	
WHAT IS YOUR IMMEDIATE CONCERN?	

Please Answer Yes or No to the Following:

Are you fearful of dental treatment? Scale of 1 to 10 (very)

Personal History

Have you had an unfavorable dental experience:	❑ Yes	❑ No	**Have you ever had complications from past dental treatment?**	❑ Yes	❑ No
Have you ever had trouble getting numb or reactions to local anesthetic?	❑ Yes	❑ No	**Do you currently have dentures, dental implants, or partials?**	❑ Yes	❑ No
Do you premedicate for your dental appointments?	❑ Yes	❑ No			

If yes, please explain:

Smile Characteristics

Are you self conscious about your teeth?	❑ Yes	❑ No	**Have you ever whitened (bleached) your teeth?**	❑ Yes	❑ No
Is there anything about the appearance of your teeth that you would like to change?	❑ Yes	❑ No			

Bite and Jaw Joint

Do you grind or clench your teeth?	❑ Yes	❑ No	**Do you have problems with your jaw joint or facial muscles? (pain, sounds, limited opening, locking, popping)**	❑ Yes	❑ No
Do you have tension headaches or sore teeth?	❑ Yes	❑ No	**Do you wear or have you ever worn a bite appliance?**	❑ Yes	❑ No
Do you play any sports?	❑ Yes	❑ No	**If so do you wear an athletic mouth guard?**	❑ Yes	❑ No

Tooth Structure

Do you have a dry mouth?	❑ Yes	❑ No	**Are any teeth sensitive to hot, cold, biting or sweets?**	❑ Yes	❑ No
Are any of your teeth causing you pain?	❑ Yes	❑ No			

Please Answer Yes or No to the Following:

Gum and Bone

Have you ever been diagnosed or treated for periodontal disease?	❑ Yes	❑ No	**Do your gums bleed when brushing, flossing or eating?**	❑ Yes	❑ No
Do you experience bad breath?	❑ Yes	❑ No	**Do you suffer from mouth ulcers or sores?**	❑ Yes	❑ No
Do you snore or have been diagnosed with sleep apnea?	❑ Yes	❑ No			

Patient Signature:	
I agree that the above field represents my signature. ❑	
Date:	**Parent, Guardian, Legal Representative Signature:**
Doctor's Signature:	**Date:**