CAMBRIDGE Family Dental

Patient Dental History

Patient Name:_____ Date of Birth:___/___/___

E-mail Address:_____

Name of Previous Dentist:

_____

Date of Last Exam:_____

Date of Last Cleaning:_____

Emergency Contact:_____

Relationship to patient:_____

Phone Number:_____

1) How did you hear about our office?

- ☐ Google
- ☐ Insurance
- ☐ Friend or Family
- ☐ Postcard
- ☐ Other:_____
- ☐ Drive By
- ☐ Facebook
- ☐ Newspaper
- ☐ Share-a-Smile referral

2) Have you ever been told you have gum or periodontal disease? YES NO

If yes, was it treated? YES NO

3) Do you feel any pain in your mouth? YES NO

4) Do you have any sores or lumps in or near your mouth? YES NO

5) Have you ever had any clicking, popping or other difficulty with your jaw? YES NO

6) Have you ever had any orthodontic treatment? YES NO

7) Are you interested in whitening or straightening your teeth? YES NO

8) Do you snore or have you been told that you snore? YES NO

9) Do you have a CPAP machine? YES NO

10) Have you ever had a bad experience at the Dental Office? If yes, please describe:

_____

_____

_____

11) Are in interested in sedation? YES NO

<u>If you are interested in sedation, please respond to the following 2 questions:</u>

A) Have you or any members of your family had any previous complication with being sedated? YES NO

B) Do you have any concerns that you wish to discuss with the Doctor and his assistant in private? YES NO