Smiles on Haymarket
4420 Costello Way Haymarket VA
(703)753-8129

dentalcare.com

Dental History

Last Name _____ First Name _____ ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms.

Address _____

City _____ State _____ Zip _____

1. Date of last dental visit? ____/____/____ Date of last dental x-rays? ____/____/____

2. Reason for last visit? _____

3. Do you have any concerns about previous dental care or this dental visit? _____

_____

4. **Do your gums bleed?** (circle) Yes No

5. **Are your teeth loose?** (circle) Yes No

6. **Have you ever been told you have gum disease?** (circle) Yes No

7. **Have you ever been told you have bad breath?** (circle) Yes No

8. **Are your teeth sensitive to?** (circle all that apply) Sweets Cold Heat Pressure

9. **Have your ever had any pain in your jaw joints (clicking, popping)?** (circle) Yes No

10. **Are you happy with your smile?** (circle) Yes No
If no, please explain: _____

11. What would you change about the present condition of your mouth? _____

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I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand it is very important to report any changes or updates in my medical status. I give permission to obtain from my physician any additional information regarding my medical history needed to provide me with the best treatment possible.

Patient Signature _____ **Date** _____

If you have completed this form for another person, please print your name and sign below along with your relationship to patient.

Print _____ **Relationship** _____

Signature _____ **Date** _____

Health History Update: On a regular basis we will be asking about any changes in your medical history.

Date	Changes/Comments	Signature of Patient and Dentist
____/____/____	_____	_____
____/____/____	_____	_____
____/____/____	_____	_____