New Patient Dental History Form

Patient Information

Full Name

Date of Birth

Address

Phone Number

Email

Dentist Information

Previous Dentist

Date of Last Dental Visit

Dental History

Are you experiencing any dental problems?

- [ ] Tooth pain
- [ ] Bleeding gums
- [ ] Sensitivity
- [ ] Swelling
- [ ] Other

If other, please specify

Have you had any of the following?

- [ ] Braces
- [ ] Gum treatment
- [ ]

Extractions

Root canal

Denture/Partial

Medical History

Physician's Name

Please list any medical conditions

Please list any medications

Any drug allergies?

Additional Information

Do you have any specific dental concerns or goals?