Penniall
family dental

DENTAL HISTORY

Patient Name_____ DOB_____

1. What is the reason for your visit today? _____
   _____

2. Date of Last Dental Visit_____Date of Last Dental Cleaning_____
   Date of Last Full Mouth X-rays_____

3. What was done at your last dental visit?_____

4. What was you previous dentist's name?_____
   Address_____
   Telephone_____

5. Do you feel nervous about having dental treatment? Yes No
   If yes, what is your biggest concern?_____

6. Have you ever had an upsetting dental experience? Yes No
   If yes, please describe_____
   _____

7. Is there anything else about having dental treatment that you would like us to know?
   _____
   _____