Bhavana Thakur, D. D.S. 281 East Hamilton Ave #3, Campbell, CA 95008 Phone 408-871-0877

Dental History Form

Patient Name: First _____ MI___ Last_____ Nickname_____

What are your goals in coming to our office today? _____

What is important to you in a dentist or dental office? _____

What has been your experience with the dentist in the past? _____

Former Dentist: _____ Phone: _____

Address: Street_____ City: _____ State: _____ Zip: _____

If you left your previous dentist, what are the reasons? _____

How often do you brush? _____ How often do you floss? _____

Have you ever had a local anesthetic (Novocain, etc)? YES ___ NO___

Have you ever had an allergic reaction to a local anesthetic? YES ___ NO___

Have you had any serious trouble associated with pervious dental treatment? YES___ NO___

If Yes, What? _____

Do you smoke? YES___ NO___ If Yes, What type? Tobacco___ Cigar ___ Chew___ Marijuana____Other_____

Does dental treatment make you nervous? NO__ YES___ Slightly__ Moderately___ Extremely___

Check all that apply:

__ Bleeding gums	__Bad Breath	__Grinding/Clenching Teeth	__Loose Teeth or broken fillings
__Sensitivity to sweets	__Sensitivity to hot	__Clicking or popping	__ Jaw pain
__Periodontal Treatment	__Sensitivity to cold	__Sores or growths in mouth	__Sensitivity when biting
__Discolored teeth	__Old fillings	__Old crowns	__Food collection between teeth

Have you ever had orthodontic treatment? __YES __NO If yes, when? _____

Have you ever had periodontal (gum tissue) treatment, such as deep cleaning, root planning, or periodontal surgery? __YES __NO

If yes, when? _____ Have you whitened your teeth in the past? __ YES __NO

Are you interested in learning more about the following? (Check all that apply)

__ Teeth whitening	__Tooth-colored filings	__At home oral hygiene care
__Orthodontic Treatment	__Dental implants	__Periodontal Treatment during pregnancy
__ Veneers	__Oral hygiene for toddlers	__How to prevent periodontal disease