DENTAL IMPLANT CENTERS®
James Khazian DMD. AFAAID. FICOI.

Patient name: _____ **Dental History form**

All information is confidential

What is the reason for your visit today?		
Date of your last dental visit:	Date of last dental cleaning:	Date of last x-rays:
Your dentist name and phone number		
How often do you have dental check up/cleaning?		
How often do you brush your teeth?	Floss your teeth?	
What other dental aids do you use?		

Do you:	Yes	No
Have any dental problem, pain, or sensitivity now? If yes, please describe:	☐	✔
Feel nervous about having dental treatment? If yes, what is your biggest concern:	✔	☐
Clench or grind your teeth while awake or sleep?	☐	✔
Breath through your mouth?	✔	☐
Have a tired jaw, especially in the morning?	✔	☐
Chew tobacco?	☐	✔

Have you ever had:	Yes	No
An upsetting dental experience?	✔	☐
Orthodontic treatment?	✔	☐
Periodontal (gum) surgery?	✔	☐
Oral surgery?	✔	☐
Facial joint pain?	✔	☐
Difficulty opening and closing your mouth?	✔	☐
Clicking or popping of jaw?	✔	☐
Mouth odor or bad taste?	✔	☐
Dry mouth?	✔	☐
Food caught between your teeth?	☐	✔

Please answer the following	Yes	No
Would you like to improve the appearance of your teeth?	✔	☐
Would you like to have whiter teeth?	✔	☐
Is there anything else about your dental condition that you would like us to know? If yes, please describe here: ggggg	✔	☐

Patient's/guardian signature _____ **Date** _____

Submit Via Email