Lauren Yasuda Rainey, DDS, Inc.
General Dentistry
2519 Ashby Avenue, Berkeley, CA 94705
www.BerkeleyDentalOffice.com

Dental History

First Name: _____ Last Name: _____ Date of Birth: _____

I. Previous Dentist.

Date of Previous Dental Visit: _____ Date of Last X-rays: _____

Reason for Previous Dental Visit: _____

Previous Dentist Name: _____ Location (City, State): _____

If you left your previous dentist, what was the reason? _____

II. Your Visit.

What are your goals in visiting our practice? _____

What is important to you in a dental practice? _____

III. At-Home Oral Hygiene Care.

How often do you brush your teeth? _____

How often do you floss? _____

How often do you use mouthwash? _____

Do you use any other dental products? _____

IV. Current Dental Condition.

Please check Yes or No for each.

1. Are you currently experiencing dental pain or discomfort? ☐ Yes ☐ No
   If YES, explain: _____
2. Do your gums bleed? ☐ Yes ☐ No
   If YES, explain: _____
3. Are your teeth loose? ☐ Yes ☐ No
   If YES, explain: _____
4. Do you wear dentures or partials? ☐ Yes ☐ No
   If YES, explain: _____
5. Have you ever been told you have gum disease? ☐ Yes ☐ No
   If YES, explain: _____
6. Are your teeth sensitive to hot, cold, sweets or pressure? ☐ Yes ☐ No
   If YES, explain: _____
7. Have your ever had any clicking, popping or discomfort in the jaw? ☐ Yes ☐ No
   If YES, explain: _____
8. Do you grind your teeth? ☐ Yes ☐ No
   If YES, explain: _____
9. Do you wear an occlusal guard? ☐ Yes ☐ No
   If YES, explain: _____
10. Have you ever had orthodontic treatment (i.e. braces)? ☐ Yes ☐ No

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If YES, explain: _____

11. Do you have dry mouth? ☐ Yes ☐ No
If YES, explain: _____
12. Does food or floss catch between your teeth? ☐ Yes ☐ No
If YES, explain: _____

V. Past Dental Experience.

Please check Yes or No for each.

13. Have you had negative dental experience associated with previous dental care? ☐ Yes ☐ No
If YES, explain: _____
14. Are you fearful of dentistry or have anxiety associated with dental treatment? ☐ Yes ☐ No
If YES, explain: _____
15. Have you ever been pre-medicated for dental treatment? ☐ Yes ☐ No
If YES, explain: _____
16. Have you ever had a reaction to anesthetic used with your dental treatment? ☐ Yes ☐ No
If YES, explain: _____

VI. Smile Confidence.

Please check Yes or No for each.

17. Are you happy with your smile? ☐ Yes ☐ No
If YES, explain: _____
18. Would you change anything about the present condition of your mouth? ☐ Yes ☐ No
If YES, explain: _____
19. Is there anything else you would like us to know about your dental health or history? ☐ Yes ☐ No
If YES, explain: _____

I certify that I have read and understand the above and that the information given on this dental history form is accurate. I understand the importance of a truthful dental history and that my dentist and her staff will rely on this information to treat me. I acknowledge that my questions, if any, related to the above have been answered to my satisfaction.

_____ _____

Signature of Patient (Parent or Guardian) Date