Dental History

Dr. Robert R. Hallman
Monteith Commons
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404. 261.3231

Patient Name: ____ Date: _______________

What is the reason for your visit to us today? ____

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Are you aware of any dental problems? ____

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Approximate date of your last dental visit: ____

What procedures were done then? ____

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Did you see the hygienist on that last visit? ____

Prior dentist's name: _________________________ Phone number: ________________________

Have you ever had any complications with previous dental treatment? ____________________________

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Do you currently have any dental implants, bridges, partials or dentures? __________________________

Has it ever taken you over thirty minutes to numb for a dental procedure? _________________________

Do you prefer to have **no** anesthesia during dental procedures? ________________________________

Do you take aspirin? __________ How many? ___________ How often? _______________________________

Have you ever had a fast heart rate from a local anesthetic? ____

Do you use nitrous oxide for dental restoration? ____

Would you like your teeth to be whiter? ____

Have you ever had an unpleasant dental experience or is there anything about dentistry that you especially dislike? ____

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Do you think it is possible for us to avoid the above? How? ____

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If you could change anything about your mouth, teeth or smile, what would it be? _________________________

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Is there anything not included on this that you would like to discuss with Dr. Hallman? _____________________

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